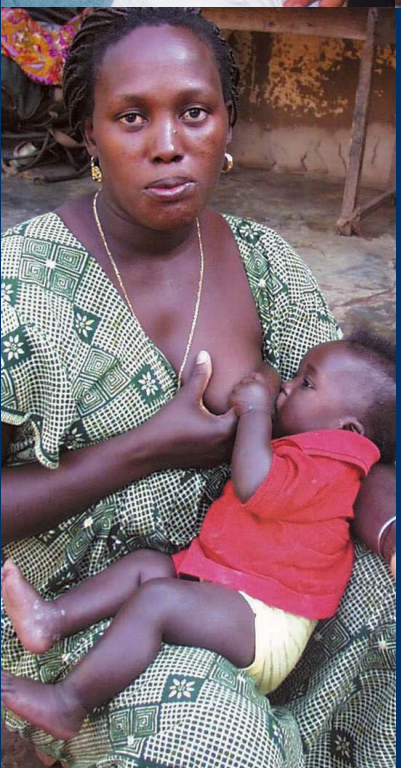
Infant Feeding in Emergencies



Module 2 Version 1.1

for health and nutrition workers in emergency situations

for training, practice and reference

Developed through collaboration of ENN, IBFAN-GIFA, Fondation Terre des hommes, Action Contre la Faim, CARE USA, Linkages, UNICEF, UNHCR, WHO and WFP.

December 2007

Top right: Kent Page, UNICEF, DRC, 2003.
Vertical strip, from top: Mae La camp, Thailand, O.Banjong, 2001.
Guatemala/LINKAGES, Maryanne Stone-Jimenez.
M.Jakobsen,Guinea Bissau, 1987.

The development of this training material would not have been possible without the contributions of time and effort of nutrition and health professionals too numerous to mention. This document draws on existing best practice and published evidence where it exists. Where it does not it draws on extensive experience and a broad base of expert opinion.

This work is the product of interagency collaboration among the following agencies which provided resources in terms of staff time, financial support or both:

UNICEF
UNHCR
WHO
WFP
IBFAN - represented by its Regional Coordinating Office in Geneva (GIFA)
Emergency Nutrition Network (ENN)
Fondation Terre des hommes
Action Contre la Faim (ACF)
CARE USA
LINKAGES

This material is not a formal publication of any of the agencies mentioned above and should be considered a 'living document' for use, comment and further development, and will be updated as necessary.

Comments, additional inputs and experiences of using this material are welcome and should be sent to ENN at the address below.

In response to field feedback to the first version of Module 2, Version 1.1 (December 2007) has incorporated four sections into one booklet. While the content remains essentially the same this reprint provides reference to a number of key materials that have been produced or updated since the module was first produced (see Key Reference Update p.5). In addition, it updates the section on HIV (Section 2, Core Manual) and excerpts from the Operational Guidance on Infant and Young Child Feeding in Emergencies (v2.1, February 2007). It is the first reprint of Module 2 in English. The Interagency Standing Committee (IASC) Nutrition Cluster has funded this update.

The online version is available at
http://www.ennonline.net/ife

Print copies will be made available and should be requested from ENN at the address below.

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Key Definitions

Artificial feeding:
Feeding with breastmilk substitutes.

Breastmilk substitutes (BMS):
Any food being marketed or otherwise represented as a partial or total replacement of breastmilk, whether or not suitable for that purpose; in practical terms this includes milk or milk powder marketed for children under 2 years and complementary foods, juices and teas marketed for children under 6 months.

Complementary feeding (previously called "weaning"):
The giving of complementary foods in addition to breastmilk or infant formula.

Complementary foods:
Any food, whether commercially manufactured, or locally,or home-prepared, suitable as a complement to breastmilk or infant formula when either becomes insufficient to satisfy the nutritional requirements of the infant (from the age of 6 months). Complementary foods marketed for children under 6 months are breastmilk substitutes.
Note: complementary foods should not be confused with supplementary foods which are commodities intended to supplement a general ration and used in emergency feeding programmes for the prevention and reduction of malnutrition and mortality in vulnerable groups.

Commercial baby foods (industrially-formulated complementary foods):
Branded jars or packets of semi-solid or solid foods, teas and juices.

Exclusive breastfeeding:
Only breastfeeding or breastmilk feeding and no other foods or fluids (no water, no juices, no tea, no pre-lacteal feeds), with the exception of drops or syrups consisting of micronutrient supplements or medicines.

Infants:
Children less than 12 months.

Infant feeding equipment:
Bottles; teats; syringes (usually in an institutional setting); or baby cups sometimes fitted with lids.

Infant formula:
A breastmilk substitute formulated industrially in accordance with Codex Alimentarius Standards (joint FAO/WHO food standards programme) to satisfy the normal nutritional requirements of infants up to six months of age. Infant formula may also be prepared at home in which case it is described as "home-prepared".

The International Code:
The International Code of Marketing of Breast-Milk Substitutes, adopted by the World Health Assembly (WHA) in 1981 and all relevant WHA Resolutions, referred to here as "the International Code" (4). The aim of the International Code is to contribute to the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding and by ensuring the proper use of breastmilk substitutes (see definition above) when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The Code and all relevant WHA Resolutions set out the responsibilities of the infant food industry, health workers, national governments and concerned organisations in relation to the marketing of breastmilk substitutes, bottles and teats.

Optimal infant and young child feeding:
Exclusive breastfeeding for the first six months of life, followed by continued breastfeeding with adequate complementary foods for up to two years and beyond.

Other milks:
Dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk; soy milks.

Relaction:
The re-establishment of breastfeeding after the breastmilk supply has stopped, or is reduced.

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Key Reference Update

The following are key references that have been produced or updated since this module was first printed (along with the chapters they are particularly relevant to). While the module has been updated to include references the content has not been revised, with the exception of updates to the section on HIV and excerpts of the Operational Guidance.

Operational Guidance on Infant and Young Child Feeding in Emergencies, v2.1, February 2007. IFE Core Group. Available at *http://www.ennonline.net/ife (Chapters 8 and 9)*

Technical WHO Guidelines for the safe preparation, storage and handling of powdered infant formula are available at *http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html (Chapter 9)*

Policy of the on the acceptance, distribution and use of milk products in refugee settings (2006). Available in English and French. Download from *http:///www.unhcr.org* or *http://www.ennonline.net/ife* or *email: ABDALLAF@unhcr.org or HQTS01@unhcr.org (Chapter 9)*

WHO HIV and Infant Feeding Technical Consultation Consensus Statement. Held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants. Geneva, October 25-27, 2006. Available at: *http://www.who.int/child-adolescent-health/publications/NUTRITION/consensus_statement.htm* and Annex 19 *(Chapters 8 and 9)*

Introduction

This is the second of two Interagency Working Group Modules on Infant Feeding in Emergencies (IFE). It is based upon the interagency joint Operational Guidance document of July 2001, given in Module 1. This reprint has updated the references (see Key Reference Update p.5) including quotes to the latest Operational Guidance (v2.1, February 2007), and has updated the section on HIV and infant feeding.

Scope

The title "Infant Feeding in Emergencies" has been chosen as the Modules cover breastfeeding and artificial feeding in natural disasters, complex emergencies, and large-scale population displacements. Major problems are often experienced with infant feeding, increasing the risk of malnutrition and death in this vulnerable age group.

Complementary feeding (giving other foods in addition to breastmilk or artificial feeds) is essential from six months. We do not deal with it fully here because there is little space to describe the technical/basic principles and the time allowed to teach the Module is already short. We hope to develop a third Module in which we will cover complementary feeding in depth.

The challenge

Natural disasters and complex emergencies usually have a devastating impact on peoples' lives. People become homeless and often have to leave their area of origin. In complex emergencies, health systems may have collapsed and access to primary health care services is either limited or completely unavailable.

In emergencies, health and nutrition workers face the daunting task of caring for large numbers of women and infants many of whom are ill, malnourished and traumatised by their experiences. Many women will have lost their children, husbands and/or other members of their families; many suddenly become the heads of households and have to take care of vulnerable family members. The impact on women can be tremendous, mentally as well as physically. So in emergency settings, women, especially those with infants, need extra care and attention.

Health and nutrition workers may know the value of breastfeeding and the difficulty of artificial feeding in such circumstances, but few have received training in these subjects. However, they are likely to see women who are so weak that they seem unable to produce milk, or who have lost confidence in their ability to breastfeed. Other women, who fed their infants adequately with breastmilk substitutes before the emergency, may now be facing the task with limited resources, in a far more difficult environment.

The challenges for these workers are enormous. They must make sure there are appropriate conditions and adequate support for women to breastfeed, know when agreed criteria for artificial feeding are fulfilled, cope with limitations in resources and lack of safe water, and know how to deal with donations of infant foods that might be inappropriate. This is why health and nutrition workers need access to the knowledge and skills to enable them to help women appropriately.

Objectives

Module 1 provides an overall introduction to infant feeding in emergencies, and explains why it is an important concern. It discusses the many challenges, describes relevant aspects of the International Code of Marketing of Breastmilk Substitutes, gives agreed Operational Guidance for emergency relief staff and policy makers, based on Operational Guidance 2001 (the latest version is Operational Guidance v2.1 2007; see Key Reference Update p.5) and suggests how to establish conditions that support breastfeeding and reduce dangers of artificial feeding. It can be used by itself, or as preparation for Module 2, according to the audience.

As part of the Additional Material section, which complements the Core Manual, Module 2 includes information on relactation, and the management of breast conditions. Reflecting realities in the field, and in the context of a lack of guidance on these issues, *Severely malnourished infants less than 6 months old*, and *When children are not breast fed*, are also included as part of the Additional Material.

Module 2 aims to provide health and nutrition workers with the basic knowledge and skills to help both breastfeeding and artificially feeding women. The first task is to support breastfeeding women, so that they do not lose confidence and introduce artificial feeds unnecessarily. The next task is to identify and help women who have feeding difficulties. The aim is to restore the feeding that is most appropriate for their infant or young child. Those caregivers for whom artificial feeding is the only option also need help.

Target audience

For Module 1, the target is all emergency relief workers, including those involved in site management, or responsible for technical tasks such as water, sanitation, and supplies. These people are important in establishing conditions for adequate infant feeding, but may be only indirectly concerned with the care of mothers/caregivers and infants.

For Module 2, the target is health and nutrition workers who are directly concerned with the care of mothers/caregivers and infants. It provides specific practical knowledge about how to help individual mothers and other caregivers with infant feeding.

Module 2 should be used after trainees have studied Module 1. Module 2 does not repeat the content of Module 1.

Limitations of recorded experience

Many important practical questions on infant feeding remain unanswered because they have not yet been asked or examined under field conditions. We hope that this module will encourage workers to record their experience in a more systematic way, so that we can all learn more about the most effective approaches. In the meantime, we know enough to make big improvements to infant feeding.

Options for conducting the training

You can use Modules 1 and 2 to prepare staff for humanitarian assistance work, or to train new workers as they join health and nutrition teams in existing emergencies.

Each Module consists of :

- A Manual to be given to each participant.
- Overhead Figures, for use as transparencies or a flip chart.
- Presenter's Notes (in Module 1).

The Manuals include small copies of all the overhead figures, to make private study easier.

Those studying Module 2 should already have studied Module 1, and should have its Manual available for reference. Module 1 can be rapidly presented in one hour, although it is recommended to allow two or three hours, for a more interactive approach. The Presenter's Notes for Module 1 give plans for one-, two-, and three-hour use.

Module 2 consists of five Core Parts, which can be covered in five hours of group teaching. Additional Parts give more details on specialised topics.

Each Additional Part can be studied or taught separately. If they are all included with the Core Parts in group teaching, the entire session would take a full day.

The simplicity of the material in Module 2 makes it suitable for training community health workers from the emergency-affected population, who are often needed to help support infant feeding.

All parts of the Manuals may be used for private study, as on-the-job guides, and for reference. The information has been simplified and streamlined, so that health and nutrition workers with little time and little opportunity for study can learn and use effective interventions with the minimum of training.

How Module 2 is arranged

The Core Manual comprises parts 1 to 5 which deal with basic information on:

- how breast milk is produced and flows and how babies suckle
- the support women need to breastfeed effectively
- how to assess infant feeding and
- how to help mothers and other caregivers overcome any feeding difficulties.

Additional Parts 6 to 9 deal with specific conditions:

- relactation, and
- breast conditions and specific situations
- severely malnourished infants under six months old and
- when infants are not breast fed.

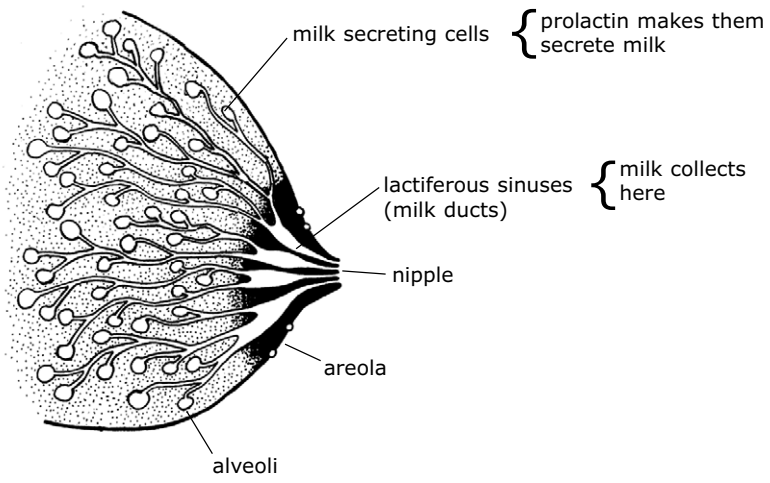
1 How Breastfeeding Works

1.1 Effective suckling

If we could look inside a breast, this is what we would see.

IFE 2/1

Inside the breast **IFE 2/1**



Adapted from WHO/UNICEF BFC, 1993

When the milk secreting cells have produced the milk (see section 1.3), it flows into wide ducts called *lactiferous sinuses* (milk ducts) that are beneath the *areola* (the darker skin around the nipple).

A baby needs to *suckle effectively* to get the breastmilk. To do this, he or she (we will say *s/he*) must take enough of the breast into his/her mouth to put pressure with his/her mouth on the milk ducts. This is called being *well attached* to the breast, or *good attachment*.

A baby cannot get the milk by sucking[1] only on the nipple.

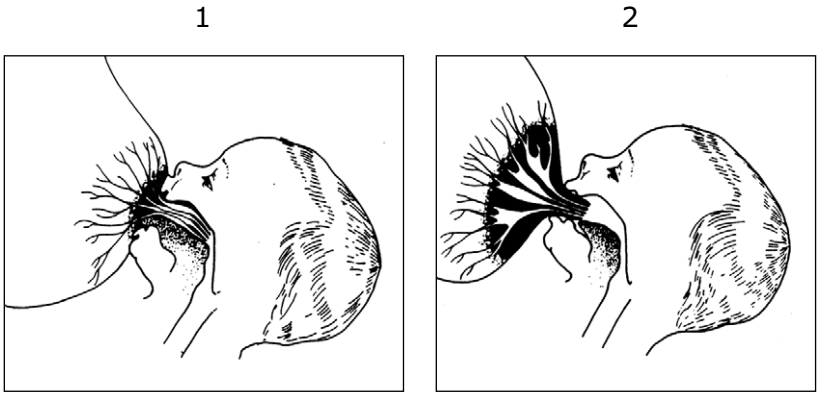
[1] Sucking is a different action from suckling

Good and poor attachment

The next two pictures show what happens inside a breastfeeding baby's mouth.

IFE 2/2

Inside the baby´s mouth **IFE 2/2**



In picture 1:

- The nipple and areola are stretched out to form a long teat in the baby's mouth.
- The lactiferous sinuses are inside the baby's mouth.
- The baby's tongue is reaching forward over his/her lower gum, so that it can press the lactiferous sinuses and press out the milk. This is called suckling.
  This baby is well attached and can easily get the milk. The baby can suckle effectively. In other words the baby's mouth is working in the right way to get the milk and to stimulate the breast to make more milk.

In picture 2:

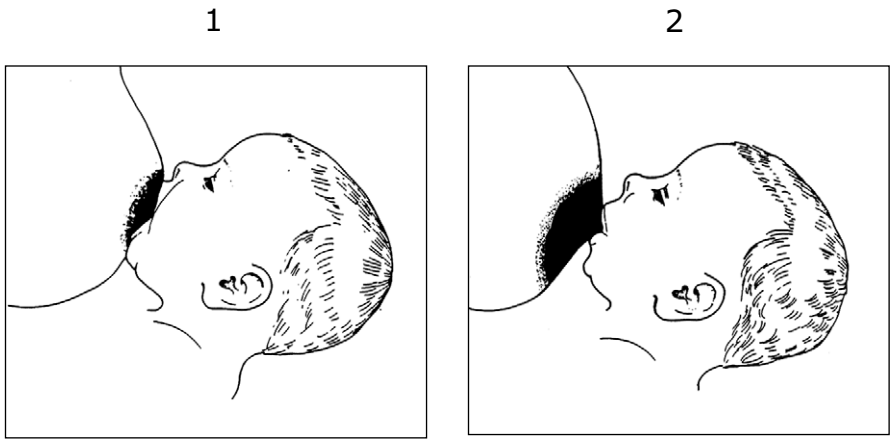
- The nipple and areola are not stretched out to form a teat.
- The lactiferous sinuses are outside the baby's mouth.
- The baby's tongue is back inside the mouth, and cannot press on the lactiferous sinuses.
  This baby is poorly attached. S/he is sucking only on the nipple, which can be painful for the mother. The baby cannot get the milk easily or suckle effectively.

How to decide if a baby is well or poorly attached

We need to be able to decide whether or not a baby is well attached by looking at the baby feeding.

IFE 2/3

Observing attachment at the breast IFE 2/3



Picture 1 shows signs of good attachment:

- More areola is above the baby's mouth than below.
- The baby's mouth is wide open.
- The lower lip is turned out.
- The chin is touching the breast (or nearly touching).

If you can see all these signs, then the baby is well attached. When the baby is well attached, it is comfortable and painless for the mother, and the baby can suckle effectively.

Picture 2 shows signs of poor attachment:

- Sometimes equal amounts of areola are above and below the mouth.
- The mouth is not wide open.
- The lower lip is pointing forward. It may also be turned in.
- The chin is away from the breast.

If you see any one of these signs, then the baby is poorly attached and cannot suckle effectively. If the mother feels discomfort, that is also a sign of poor attachment.

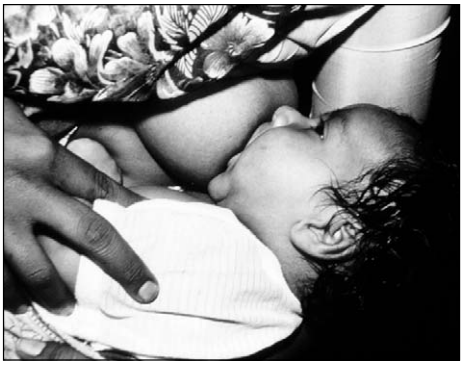
Evaluating attachment at the breast (exercises)

Decide which signs of good and poor attachment you can see in the following photographs. Consider whether the babies are well or poorly attached. You may not see all the signs clearly, so decide from those you can see.

IFE 2/4

Evaluating attachment at the breast **IFE 2/4**

1 2



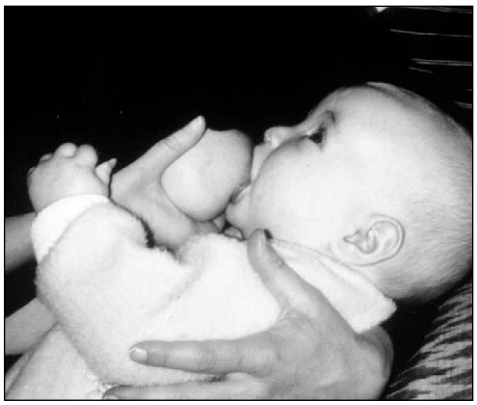
In photo 1, we can see more areola below than above the mouth and the mouth is not wide open. The baby's lower lip is not turned out and the chin is away from the breast. So the baby is poorly attached.

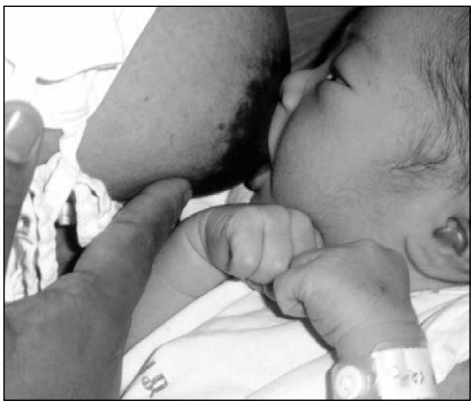
In photo 2, the areola is not clear, but we can see that the baby's mouth is open wide, the lower lip is turned out and the chin is close to the breast. So the baby is well attached.

IFE 2/5

Evaluating attachment at the breast **IFE 2/5**

1 2





In photo 1, we can see more areola above the mouth, and the mouth is wide open. The lower lip is turned out, and the chin is close to the breast. So the baby is well attached.

In photo 2, we can see more areola below the mouth, and the mouth is not wide open. The lower lip is turned outward, but the chin is far away from the breast. So the baby is poorly attached.

Signs that a baby is suckling effectively

If a baby is well attached, s/he is probably suckling well and getting breastmilk during the feed. But you need to be able to check.

Signs that a baby is "drinking in" the milk and suckling effectively are:

- The baby takes slow, deep sucks, sometimes pausing.
  - The pauses are to allow more milk to flow into the lactiferous sinuses/milk ducts.
- You can see or hear the baby swallowing.
- The baby's cheeks are not drawn inward and are rounded during a feed.
- The baby finishes the feed and releases the breast by himself or herself and looks contented.

Signs that a baby is not getting the milk easily and that suckling is ineffective/poor are:

- When the baby makes only rapid sucks.
- When the baby makes smacking sounds.
- When the baby has cheeks drawn in.
- When the baby fusses at the breast, and comes on and off the breast.
- When the baby feeds very frequently or for a very long time and is not contented at the end of a feed.

Helping a mother with positioning and attachment

Positioning means how the mother holds her baby. If her baby is poorly attached, you can help the mother to position the baby so that s/he attaches better. If the baby is well attached and suckling effectively, don't bother about the position.

The mother can be in any comfortable position – for example, sitting on the ground or on a chair, lying down, standing up, or walking.
If she is not comfortable, she may welcome support for her back.
The baby too can be in different positions, such as under the mother's arm, or lying alongside her.

There are **four key points** that are the same for any position. The baby's body must be:

- **straight**, so that the neck is not twisted or bent forward or far back
- **facing the breast** (the baby's nose should face the nipple as s/he comes to the breast)
- **close** to the mother's body, and
- **supported.** A young infant needs the whole body supported, not just the head and neck. An older child may like to have his or her back supported even though s/he sits up to breastfeed.

To start breastfeeding the mother:

- positions the baby so the nose is near the nipple
- touches the baby's mouth with her nipple so the baby opens her/his mouth wide and reaches up a little
- moves the baby onto her breast so the baby takes a big mouthful.

The mother may want to support her breast from below. But she does not need to hold it away from the baby's nose, or pinch it between two fingers. These actions are quite common in some societies and may prevent good attachment. A baby will have no difficulty breathing if well attached.

If a mother is feeding in a new position, check the baby's attachment and watch the suckling. Make sure, through sensitive guidance, that the mother knows how to attach the baby herself and how to recognise effective suckling.

1.2 Good milk flow and confidence

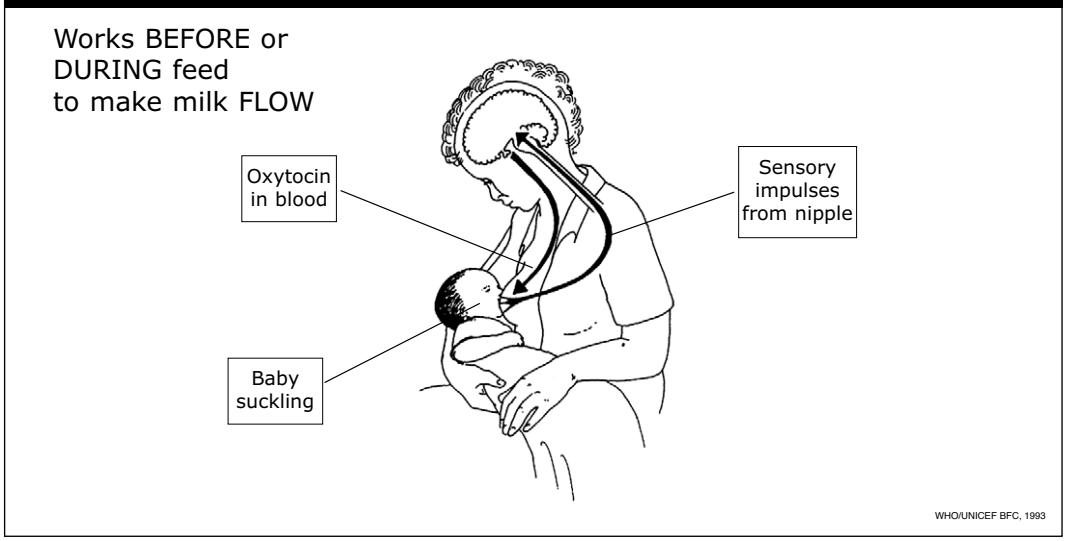
Two things affect milk flow:

- The baby's suckling. This also affects milk production (see section 1.3).
- The mother's feelings.

The breasts of a breastfeeding mother are never completely empty.
Milk is produced and stored in the breast all the time.

IFE 2/6

Milk flow: the oxytocin reflex **IFE 2/6**



When a baby suckles, a hormone called oxytocin is released. Oxytocin makes the stored breastmilk flow through ducts towards the nipple. Mothers sometimes are aware their milk is flowing. They feel a tingling sensation in their breasts, or they see the milk leaking out.

A woman's feelings affect milk flow (and oxytocin).

- Good feelings, such as pleasure in touching, seeing or hearing her baby, or feeling confident that her milk is best, help her milk to flow.
- Bad feelings, such as worries about her milk, or rejection of the baby, may interfere with the flow of milk.
- The extreme stresses and disturbances of emergencies sometimes seem to interfere with milk flow. Fortunately, any stopping of milk flow is usually temporary.
- Protection, shelter, and a reassuring atmosphere around a woman help her milk to flow easily again.

IFE 2/7

Companionship and protection help milk flow **IFE 2/7**

A mother does not need perfect calm or special conditions to breastfeed. Many women breastfeed easily in extremely stressful and difficult situations. Some women find that breastfeeding soothes and helps them to cope with stress.

We are not sure that stress actually reduces milk flow, but many women believe that it does. It is commonly felt that health and nutrition workers can help a mother's milk to flow well if:

- they are supportive, and build a mother's confidence, and
- they help her to find other women who also encourage and reassure her.

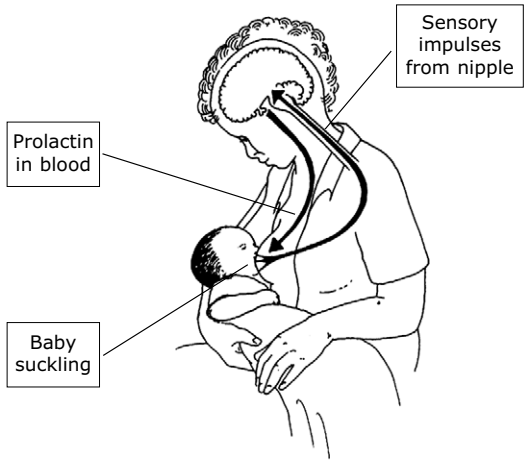
1.3 Adequate milk production

Breasts make milk in response to the suckling of an infant. There are two processes to know about:

1. Suckling stimulates release in the mother's body of a hormone called prolactin. Prolactin makes the breasts produce milk. The milk is stored in the breast.
2. Milk production slows down if a lot of milk is left in a breast at any time.

IFE 2/8

Milk production: the prolactin reflex **IFE 2/8**



WHO/UNICEF BFC, 1993

The amount of breastmilk that a mother produces depends on how much her baby suckles. The breasts make more milk if a baby suckles more (either more often, or for longer, or both). The breasts make less milk if a baby suckles less. Improving a mother's diet alone will not increase her breastmilk.

So a baby should suckle as much as possible to keep the breasts producing milk or to increase the amount.
If a baby cannot suckle, the milk should be removed frequently by expressing it (see Annex 3). Production will decrease and eventually stop if the milk is not removed.

More suckling makes more milk.

Less suckling makes less milk.

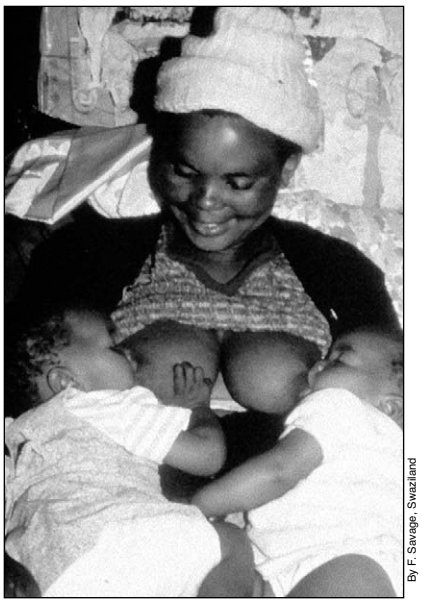
A breastfeeding mother does not have a fixed "supply" of breastmilk. She can always make more even if she is moderately malnourished. Milk production is only likely to be reduced if a woman is severely malnourished. Then the woman herself needs immediate feeding/extra food. Even in such cases the woman needs support to continue to offer her baby the breast so as to maintain the milk-making process while she recovers her own nutrition (See Parts 2 and 5).

Some other things that affect the amount of breastmilk a baby gets:

- Giving other food or drinks to the baby, even water, makes the baby suckle less, so less breastmilk is produced.
- The milk that comes later in a feed is called hind milk. Hind milk flows more slowly but contains more fat and gives the child more energy.
- In societies where pacifiers are used, these may be a sign that a woman has been having breastfeeding difficulties, associated with ineffective suckling or infrequent feeds.
- Suckling at night releases more prolactin and so more milk is produced.
- Milk production does not automatically decrease as a baby gets older – it decreases only if the baby suckles less.
- A mother with twins can produce enough milk for both babies if she is confident and receives skilled support.

IFE 2/9

Breastfed twins: Swaziland and Angola **IFE 2/9**



By F. Savage, Swaziland

Mary Lungatho, Cubal, Angola

Is the baby getting enough breastmilk?

Many mothers worry that they are not producing enough milk. This is especially likely for mothers in emergency situations, but is also true in settled conditions.

Health and nutrition workers can judge whether a baby is getting enough milk by seeing the way the baby feeds. Health and nutrition workers may also worry about breastmilk production and sometimes their own lack of confidence is passed on to the mother.

To get plenty of milk the baby needs:

- to be well attached so that s/he can suckle effectively and get the milk easily
- to have a mother whose milk flows well even if the surroundings are stressful
- to suckle frequently so that the breasts produce plenty of milk
- to suckle for as long as s/he wants during each feed to get the hind milk as well as to stimulate the breasts more.

A baby who is getting enough milk is usually:

- not visibly thin (or is getting fatter/putting on weight, if s/he was thin earlier)
- responsive and active, (appropriately for his or her age)
- gaining weight (at least 500 g /month if aged under six months) and
- passing light-coloured urine six times a day, or more. (However, one cannot use this sign, if the baby is having water, oral rehydration solution or other drinks as well as breastmilk.)

The best breastfeeding pattern

Frequent and unlimited breastfeeds are the best breastfeeding pattern throughout the infant's first year. This ensures that a baby stimulates his or her mother's breast to make all the milk that s/he needs to grow and develop healthily.

The baby should:

- suckle as often as s/he wants, day and night, without long periods of separation from the mother.
- suckle for as long as s/he wants at each feed, getting the fat-rich milk that comes later in the feed.
- have the breast kept available if s/he pauses, or lets go of the breast for some moments. - pauses do not necessarily mean that s/he has finished the feed.
- finish the first breast, and then be offered the other breast, which s/he may or may not want. Let the infant decide whether s/he wants one or two breasts at each feed. There is no rule to follow.

This breastfeeding pattern is important even after complementary foods have been introduced at six months.

1.4 Age–appropriate feeding (the right feeding for the right age)

The best way of feeding is different at different ages, so we talk about age-appropriate feeding.

Between 0 to 6 months

- Babies should start breastfeeding within an hour of birth.
- Babies should breastfeed exclusively and on demand for six months.
- Exclusive breastfeeding means that a baby is given only breastmilk (which can be expressed if necessary) but no other foods or drinks – not even water. Medicines and vitamin drops are allowed if medically necessary and are not diluted.
- Exclusive breastfeeding for six months is possible in almost all circumstances. However to achieve it, women may need ongoing help and encouragement to build their confidence.

From 6 months until 24 months (and longer if desired)

- Complementary feeding should start at the age of 6 months with breastfeeding on demand continuing until children are at least two years old. The frequency of breastfeeding and the length of breastfeeds should not be reduced.
- Women may need encouragement to continue breastfeeding up to two years or beyond. If continued breastfeeding was not usual in their community before the emergency, they need protection from any criticism that may result from breastfeeding for a long time.
- Children should be actively encouraged to eat complementary foods:
  - 2-3 times a day at the age of 6-8 months
  - 3-4 times a day at the age of 9-24 months
  - plus 1-2 snacks a day as desired. Non-breastfed children need more frequent meals (see Annex 12)
- Some families may need help in learning how to prepare and give adequate complementary foods especially if the foods available are not familiar.

The following Parts of this Module give more information on how to help mothers achieve:

- effective suckling
- good milk flow and confidence
- adequate milk production
- age-appropriate feeding

2 Supportive care for all women

Part 2 describes what health and nutrition workers can do to:

- help women to continue to breastfeed even in very stressful situations, and
- increase breastfeeding if artificial feeding was common before the emergency, and the risks of doing so have now increased.

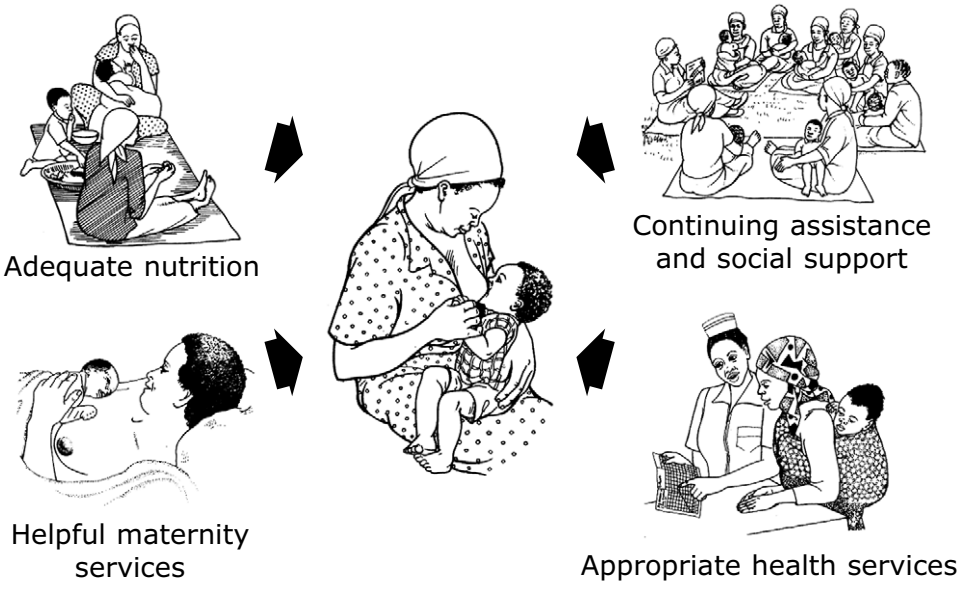
Some general conditions that make breastfeeding easier were covered in Module 1 (pp 35-6). These include camp arrangements, recognition of vulnerable groups, shelter and (where culturally required) privacy, reduction of demands on mothers' time, and increased security. These are in addition to those covered by the Code of International Marketing of Breastmilk Substitutes (see Module 1 pp 21-23).

In addition, every breastfeeding woman needs four elements of supportive care to ensure effective suckling, good milk flow and confidence, adequate milk production, and age-appropriate feeding. These are:

1. Adequate nutrition.
2. Helpful maternity services.
3. Appropriate health services.
4. Continuing assistance and social support.

IFE 2/10

Four elements of supportive care **IFE 2/10**



Adapted from F. Savage, A. Burgess - Nutrition for Developing Countries. 1993

2.1 Adequate nutrition

Food needs during lactation

A breastfeeding woman needs about 450 more kcal of energy per day than when she is not lactating.

Also, the micronutrients in breastmilk that are not stored in a woman's body, need to come from her food or from micronutrient supplements.

This means a breastfeeding woman needs an extra, small, nutritious snack or an extra fifth more of her usual daily food amount.

It is often customary for breastfeeding women to eat special foods (e.g. special soups or porridges). These may not be nutritionally necessary, but they can be important for building a woman's confidence in her milk supply because she believes they are good for her.

In emergencies the *general ration*[2] should provide sufficient energy and protein and some micronutrients if women get their full share and all they want. But it may not provide enough of all the micronutrients women need.

Supplements for lactating women

Where vitamin A deficiency is likely to occur, give lactating women 200,000 IU of vitamin A as a single dose within 6-8 weeks after delivery.

Other micronutrient supplements may also be needed.

Food supplements help to ensure that a woman is not undernourished if she becomes pregnant again.

All lactating women should eat supplementary food for at least six months and preferably for as long as they are breastfeeding. The supplementary food should provide 450 kcal a day and essential micronutrients.

Usually the supplementary food is a fortified cereal-pulse blend that provides 10-12% of energy from protein, 20-25% of energy from fat, and two thirds of the daily requirements of all the important micronutrients.

For on-site feeding, give each lactating woman the amount of supplementary food that supplies 450-500 kcal per day.

For home preparation, give each woman the amount of dry supplementary food that supplies 1000-1200 kcal per day (to allow for sharing among the family).

Effects of malnutrition on breastmilk

Mild or moderate malnutrition rarely affects the amount or quality of breastmilk that a woman produces. She uses her own body stores of nutrients to produce breastmilk.
If her diet remains inadequate for along time, the milk may contain fewer vitamins and fats as her own body stores are used up.

However, her breastmilk continues to be nourishing for her child, and provides anti-infective factors that help to protect the child against infections. No breastmilk substitute contains these protective factors.

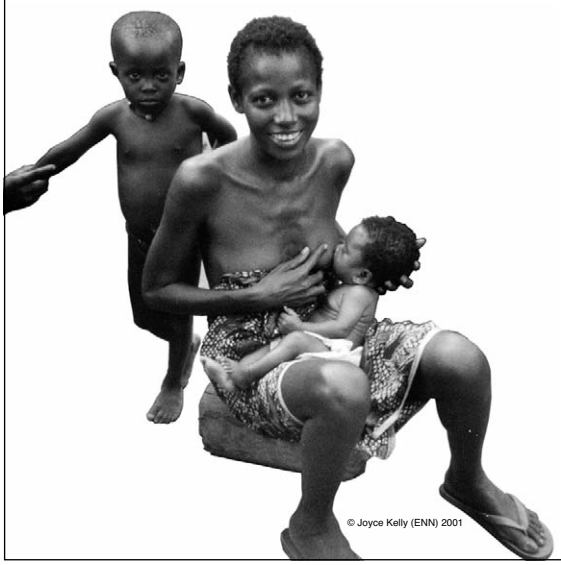
A severely malnourished woman's body has very low nutrient stores. She produces less breastmilk that contains lower amounts of fat and micronutrients. But her milk still protects the baby from infections.

[2] The UN recommendation is a general ration of 2100 kcal per day per person whether adult or child. However, this is given on a population basis, not an individual basis, and is intended to cover individual variations in need, (such as during pregnancy and lactation, or at different ages). It also assumes that food is shared according to need between household members. An infant should be registered immediately following birth, so that the household is eligible for an additional general ration. Usually the general ration includes grains, pulses, a fortified blended food, and concentrated forms of energy such as sugar or oil.

IFE 2/11

A malnourished mother breastfeeds **IFE 2/11**

Sierra Leone, 2001



Feed the mother and let her feed the infant

Monitor the weight and urine output.
Temporary supplements by cup may be needed while the mother´s milk production increases.

Breastfeeding by malnourished women

For most women, if a mother is thin and malnourished, or has an inadequate diet, this is not an indication to stop breastfeeding.

A mother should not stop breastfeeding if she is malnourished or has an inadequate diet. Stopping means her infant would not get any of the nutrients or the anti-infective factors in her breastmilk.

A thin, weak or malnourished woman needs food:

- to rebuild and protect her body stores of nutrients, and
- to enable her to produce more breastmilk.

Give any available food to the mother, and actively see what further support and care you can help her to access. Feeding the mother means she is able to produce enough milk without depleting her own body's nutrient stores.
Closely monitor the weight of any infant whose mother is malnourished and observe the amount of urine produced by the infant (see Section 1.3). The infant may need temporary supplements of other milk (as well as his/her mother´s breastmilk) until the mother's condition improves and her milk production increases (see Part 5.5).

However, giving a mother food alone does not increase breastmilk production. Her infant must also suckle often to stimulate the production of and breastmilk.
Health and nutrition workers need to make sure that every mother receives adequate food for her own health as well as support for a good breastfeeding pattern. (See Section 5.5.)

Food alone does not increase breastmilk.

Effective suckling and frequent unlimited breastfeeds build milk production.

Case study: A thin and worried mother

Mariam is thin (Mid upper arm circumference (MUAC) 20.2 cm). She feels weak, and worries that her milk may be decreasing. Her three-month old son is still exclusively breastfed. He is lively and does not look thin, and passes urine quite often.

Mariam's household receives a full emergency ration consisting of maize meal, beans, oil and sugar. She goes to a supplementary feeding centre where she receives two meals a day (700-1000 kcal/day) of a porridge made from corn soy blend (CSB), oil and sugar. Groundnuts or milk powder are added to the meal when available. On weekends, when the on-site feeding centre is closed, Mariam receives a dry take-home ration that is premixed (CBS/UNIMIX, oil and sugar).

1. Will the supplementary food increase Mariam's breastmilk production?
2. What could she do to produce more breastmilk?
3. Should she give the blended food as gruel to her son?
4. Should the baby be given supplements of infant formula?
5. What does Mariam need most to stop her feeling worried?

Answers:

1. The supplementary food will not increase her milk production, but it may improve her own nutrient status and her energy.
2. Effective suckling and a good breastfeeding pattern will increase her milk.
3. She should not give gruel to her infant at this age. She should continue to breastfeed exclusively until the infant is six months old, and eat the supplementary food herself.
4. Supplements of formula will interfere with increasing the mother's milk, and will needlessly expose the infant to health risks.
5. Mariam needs emotional support to build and maintain her confidence.

Fluids

Dehydration may interfere with breastmilk production. Mothers may arrive at refuges or intake sites already dehydrated.
Fluid intake is especially likely to be a concern when there are:

- populations on the move
- severe drought conditions
- natural disasters that contaminate water, such as floods.

Health and nutrition workers caring for mothers should:

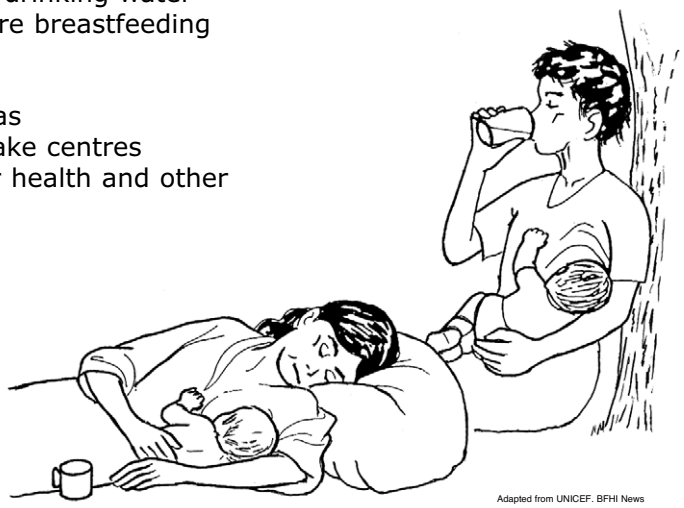
- Ideally, ensure that drinking water is freely available to breastfeeding mothers so that they can drink the amount they need.
- Ensure, if supplies are limited, that every breastfeeding mother gets an extra litre of water per day.
- Provide drinking water wherever women queue or wait in the sun a long time.
- Provide drinking water at transit rest areas for populations on the move.
- If a mother has diarrhoea, then she will need rehydration with Oral Rehydration Salts (ORS).

IFE 2/12

Prevent dehydration **IFE 2/12**

Provide plenty of drinking water wherever there are breastfeeding women in:

- transit rest areas
- registration/intake centres
- long queues for health and other services



Adapted from UNICEF. BFHI News

2.2 Helpful maternity services

The Baby-Friendly Ten Steps to Successful Breastfeeding should be an integral part of maternity services in emergencies.

5.2.2 Operational Guidance, v2.1, February 2007

Antenatal care

Many important elements of antenatal care (ANC), including prevention and correction of malnutrition and micronutrient deficiencies, should be in place.

The Baby-Friendly Ten Steps to Successful Breastfeeding (Module 1, p 53) include telling pregnant women about the benefits and management of breastfeeding.
Antenatal education is particularly important in populations with traditions of brief or only partial breastfeeding.

Try to identify pregnant women early, at registration or at their first contact with the health services. Many women may not seek health services during pregnancy.

Case study: Increased reliance on traditional birth attendants

When living in Rwanda in 1992, 94% of women obtained antenatal care from trained health personnel, and 1% from Traditional Birth Attendants (TBAs). Only 4% had no antenatal care.
Of Rwandan refugee women living in Ngara camps, Tanzania in 1995, only 19% obtained antenatal care from trained personnel and 59% obtained care [only] from TBAs. 22% of women in the camps had no antenatal care.

Lung'aho, Clause, Butera: Rapid Assessment of Infant Feeding Practices in two Rwandan Refugee Camps. San Diego; Wellstart International, 1996

One way to reach more pregnant women is to ask community breastfeeding helpers (local women who traditionally are called upon and/or trained to give support to mothers) or the mother-baby tent staff to organise antenatal breastfeeding discussion groups. (See 5.2.3 Operational Guidance v2.1, 2007)

These should cover:
- why breastfeeding is important and artificial feeding is dangerous
- recommendations of exclusive and continued breastfeeding
- the breastfeeding pattern that ensures plenty of milk
- what to expect soon after delivery, and
- correction of any widespread misconceptions.

The helpers can also listen to and talk with mothers individually about any worries and concerns.

Mothers who had breastfeeding difficulties before, had added bottle feeds or other products (e.g. gripe waters or teas), or stopped breastfeeding early, need to know that they will be helped to breastfeed their next babies more easily and for as long as they want.

Baby–Friendly care after delivery

Wherever women give birth, health and nutrition workers should help women to establish exclusive breastfeeding in the first days. Steps Four to Ten of the 'Baby-Friendly Ten Steps to Successful Breastfeeding' cover post-partum care (see Module 1, p 53).

Step 4 deals with early breastfeeding. Give the baby to the mother to hold closely skin to skin immediately after delivery. Allow the baby to stay in skin-to-skin contact on the mother's chest so she can breastfeed as soon as the baby shows signs of being ready.

Babies recognise the breast by smell, and within the first hour start to open their mouths and look around for the nipple. Often they "crawl" to the breast and attach by themselves and start suckling. Sometimes drugs used during labour may interfere with the baby´s and/or mother´s normal respones. Nevertheless skin to skin contact should be encouraged even if the baby is slow to suckle or the mother is sleepy. This first milk is called colostrum and is rich in factors that protect the baby from infections. Also, this early contact enables babies to breastfeed more easily afterwards, and helps the mother and baby to bond.

IFE 2/13

Skin-to-skin contact immediately after birth **IFE 2/13**

R. Lemoyne/UNICEF C-95 Thailand

A newborn shows that he is ready to feed and actively seeks the nipple. He is in full skin-to-skin contact with his mother.
The mother and baby are kept warm together.

Birth attendants should:

- Quickly dry the baby and then put in skin-to-skin contact with the mother for at least an hour after delivery, and until s/he has had a breastfeed.
- Make sure the baby is not wrapped up so much that skin-to-skin contact is impossible.
- Cover baby and mother so they keep warm together.
- Make sure the mother helps the baby find the breast and attaches when s/he shows readiness to breastfeed.
- Carry out other procedures (except for urgent ones such as resuscitation) while the baby is with the mother, or after the first breastfeed.

Step 5. Show the mother how to breastfeed if necessary, particularly show her how to attach the baby at the breast.

Step 6. Make sure the baby is exclusively breastfed and not given artificial feeds unless there is a medical indication.

Steps 7 and 8. Keep the baby with the mother all the time and encourage her to breastfeed whenever the baby indicates s/he want to do so – this is demand feeding and helps breastfeeding to go well.

Step 9. Do not give the baby a pacifier or feed from a bottle with a teat, as this interferes with breastfeeding.

Step 10. Make sure the mother receives continuing help and support, if possible from other breastfeeding mothers or community counsellors.

In emergencies, women may have more access to TBAs than to trained health workers such as nurses and midwives. TBAs, therefore, need to know how to make sure that breastfeeding starts early and exclusively, and how to help with attaching the baby at the breast.

Baby-Friendly maternity care does not require beds, buildings, or special equipment. Steps 4-10 can be carried out anywhere. However, women give birth and breastfeed more easily if they have privacy, warmth, and appropriate, supportive companionship during labour and the early post-partum period.

2.3 Appropriate health services

> *Integrate breastfeeding and infant and young child feeding training and support at all levels of health care.*
>
> 5.2.2 Operational Guidance, v2.1, February 2007

As well as maternity services, all other health services should encourage breastfeeding. Let people know where pregnant and breastfeeding mothers can go and whom they can ask for help.

Maternal and Child Health (MCH) services

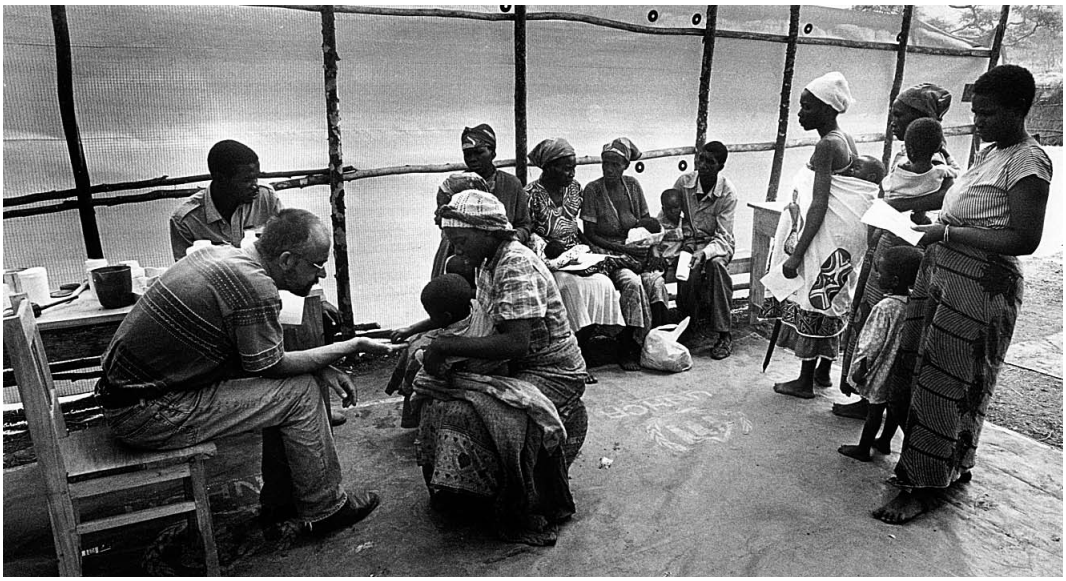
Wherever MCH services are provided, health workers need to:

- encourage age-appropriate feeding
- support breastfeeding
- recognise mothers and babies with feeding problems, for example by Simple Rapid Assessment (see Part 3).

This should happen:

- when infants are weighed
  - an infant should gain 125 g/week or 500g/month up to the age of six months
  - poor weight gain often indicates a feeding problem
- at immunization
- when infants attend for treatment of illness.

Mothers and babies with problems may need referral to an experienced health or nutrition worker who can provide more skilled help. What to do is described in Parts 4 and 5.



Chabalisa Camp, Ngara, Tanzania.

MCH clinics and dispensaries can provide supportive care and identify any difficulties with breastfeeding through Simple Rapid Assessment. Basic Aid for breastfeeding (described in Part 4.2) can also be given at this level.

UNHCR 24152/07.1994/L/TAYLOR

Illness of infant and young child

When children are ill, they may spontaneously increase breastfeeds or return to exclusive breastfeeding. Breastmilk is the best fluid and food for sick infants and young children able to take oral feeds, including infants and young children with diarrhoea.

How to manage feeding during a child's illness:

- Keep the mother and baby together – if the child is admitted to a health facility, admit the mother too. Let the mother stay and sleep with her child, both for comfort and to feed at night, and to help keep the child warm.
- If the child can suckle, encourage the mother to continue or increase breastfeeding.
- If the child cannot suckle, show the mother how to express breastmilk by hand to maintain production and keep the breasts healthy (see Part 5). You may need to ask another health worker who has learned this skill to help. See Annex 3.
- When the child is ready for enteral feeds, feed the expressed breastmilk by tube, syringe or dropper (if under supervision of health staff so equipment can be carefully cleaned) or by cup.
- If the mother is feeding expressed breastmilk at home teach her how to give it by cup (see Annex 2).
- If Oral Rehydration Solution (ORS) is given, use the same methods, never a feeding bottle.

Illness of mother

- Breastfeeding does not need to stop during most maternal illnesses or treatments.
- Breastmilk helps to protect the child against many maternal infections.
- The ill mother may find breastfeeding the easiest way to feed the child, as she can feed while lying down.

A weak and sick mother may find it impossible to carry out artificial feeding safely under emergency conditions.
This is especially so if diarrhoea contaminates her hands and lack of soap and water makes it difficult to wash them frequently.

How to manage feeding during a mother's illness:

- Treat the mother. (See Annex 1 for a summary of maternal medicines.)
- Keep mother and infant together if possible, and continue breastfeeding.
- Seek a relative or other person who can help to care for the infant, and bring him/her to the mother for breastfeeds.
- If the mother cannot breastfeed, she can hand express to keep the milk flowing and the breasts in good condition. If the mother is too weak to express her milk, ask if you, or another carer, can express the milk for her. Ask a more experienced worker to help with this if necessary (see Annex 3).
- Help the mother to increase her milk production as she recovers (see Parts 5 and 7).

Illness (especially fever), diarrhoea, or drugs used during surgery may temporarily reduce the mother's milk production. But she should breastfeed the infant as much as possible.

To check if the infant is getting enough breastmilk, monitor his/her urine output. If the infant does not pass dilute urine at least six times in 24 hours, it may be a sign that s/he is not getting enough fluid. The mother needs to drink more and to build up breastmilk production through frequent breastfeeding (see Part 4).

Case study: A mother with cholera

Nirmala has symptoms of cholera. Her five-month-old son is exclusively breastfed. He seems healthy, but he has passed urine only four times in the last 24 hours.

1. Should Nirmala and her baby be kept together or separated?
2. Does breastmilk transmit vibrio (the organism causing cholera)?
3. Should breastfeeding be stopped and the baby temporarily be given infant formula?
4. Nirmala has become severely dehydrated. What can be done?
5. The baby is urinating only 4 times in 24 hours. Should anything be done?
6. Should antibiotic treatment be given to the mother, to the baby, or to both?

Answers

(based on responses by Dr. Anjuman Ara, Senior Training Physician, ICDDR, Bangladesh)

1. Both the mother and the infant should remain together in any situation irrespective of whoever is ill. The mother may need assistance from other caregivers.

2. Vibrio is not transmitted through breastmilk. The vibrio is in the gastro-intestinal tract and the route of transmission is by fecal-oral contamination. Exclusively breastfed infants rarely develop cholera, unless the vibrio is introduced through the infant's mouth, which is prevented by exclusive breastfeeding.

3. So long as the mother is conscious (even while getting intravenous transfusion) and her dehydration is not severe, breastfeeding should be continued. Artificial feeding will reduce the breastmilk in addition to being a possible source of infection for the infant.

4. The amount of breastmilk from a deydrated mother is reduced, and she needs corrective rehydration. Severe dehydration can be improved within an hour by intravenous fluids; she should also have Oral Rehydration Solution (ORS).

5. As the infant is urinating too little, less than six times a day, he is also dehydrated. He temporarily also requires additional fluid to correct his hydration status until the mother's milk production increases. In this case, oral rehydration is essential. The ORS is given with a spoon or cup and does not interfere with the infant's interest in suckling at the breast. Breastfeeding is continued along with the ORS, so the milk production is not reduced.

6. An antibiotic is given only to the infected mother, not to the uninfected healthy infant.

Reproductive health care

Health workers providing family planning should ask each woman if she is breastfeeding. A breastfeeding mother should not be given any oestrogen-containing contraceptive pills (such as combination pills) because they can reduce breastmilk production.

Avoiding oestrogen-containing contraceptives is important both before six months, when the infant needs exclusive breastfeeding, and from six months to two years or more when frequent breastfeeding should continue, particularly during emergencies.

HIV *(this topic may be omitted where not relevant)*

All health workers should be aware of the 2006 UN policies *(Annex 19)*.
http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/consensus_statement_fr.pdf

Management of infant feeding in high HIV prevalent settings will depend on whether the operational health service is able to offer voluntary testing facilities for HIV, and appropriate referral. If testing is not available, targeting for individual treatment services and infant feeding options will not be possible and messages around breastfeeding will have to be pitched at a population level.

To make informed decisions about how to feed their babies, mothers need to know whether or not they are HIV-infected, and this requires that voluntary and confidential counselling and testing is provided and promoted. It is a fundamental principle that testing be voluntary and carried out with informed consent.

HIV and Infant Feeding: guidelines for decision-makers. UNICEF/ UNAIDS/ WHO (2003)

Risk of HIV transmission through breastfeeding

When a mother is *HIV-positive* (infected with HIV), the infant feeding decision that has to be made requires balancing the risks of breastfeeding and potential HIV transmission against the risks of not breastfeeding.

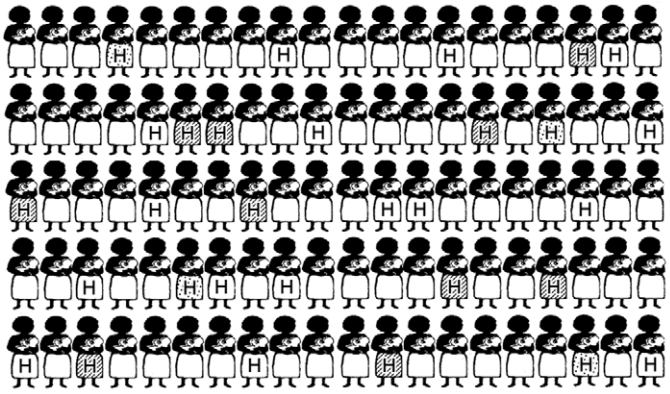
The time of greatest risk of mother to child transmission (MTCT) is during the birth when up to 30% of infants born to HIV-positive women may acquire the infection. The risk of transmission around the time of delivery can be reduced if HIV positive women are given antiretroviral therapy (ART) during the labour period. For those with accessible health services maternal ART may be started earlier in the 3rd trimester of pregnancy.

The risk of transmission of HIV by breastfeeding is sometimes over-estimated. It is often assumed that every breastfed child will be infected. In fact the additional risk of transmission through breastfeeding is estimated at 5-20% (depending on duration), for babies continuing to breastfeed up to 2 years from an HIV infected mother who is not receiving ART. This rate can be lowered by exclusive breastfeeding. On average only about 15% of infants who breastfeed from an HIV-positive mother, who is not receiving ART prophylaxis, are infected this way.

The following diagram (IFE 2/14) can help to explain the risk of MTCT. It shows 100 breastfeeding women from a population where HIV is highly prevalent.
33% (30 women) are HIV-positive (undiagnosed). About 30% of the babies born to these 30 women are infected at or before birth (10 babies). About another 13% of babies (4 babies) born to the 30 infected women may get the infection through breastfeeding. So in a population where HIV is highly prevalent and all women breastfeed, about 4 – 5% of babies become infected. This percentage will differ according to the HIV prevalence of the local population and by the pattern of breastfeeding (exclusive or mixed feeding).

IFE 2/14

If 100 women breastfed where HIV is prevalent **IFE 2/14**



It is important to balance against this risk of HIV infection, the risks to a child who does not breastfeed in a particular setting, especially if a continuing supply of suitable breast milk substitutes and hygienic preparation of artificial feeds are difficult.

When HIV testing cannot be provided

If HIV testing cannot be provided, exclusive breastfeeding for the first 6 months, followed by continued breastfeeding with adequate complementary foods for 2 years or beyond, is the recommended option[3]. This is in accord with the 2006 UN guidelines and with the 2007 Operational Guidance on infant and young child feeding in emergencies.

> *Where the HIV status of the mother is unknown or she is known to be HIV negative, she should be supported to exclusively breastfeed.*
>
> Operational Guidance 5.2.7, Operational Guidance, v2.1, February 2007

When HIV testing is provided: infant feeding options

A woman who has been tested and shown to be HIV-positive needs counselling on how to feed her infant. Current United Nations guidelines state that:

- Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.
- When replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) avoidance of all breastfeeding by HIV-infected women is recommended.

Artificial feeding
The risk of HIV transmission through breastfeeding can be reduced by artificial feeding, but this carries increased risks to the infant of other illnesses and, in many settings the risk of death from other causes. The information given to a mother needs to be adjusted to the particular emergency. The availability of breast milk substitutes and the necessary resources, such as clean water, fuel and other essentials will vary in different places, and at different phases of an emergency. A woman who chooses this option needs help to prepare artificial feeds properly (see part 6) and to ensure a sustained supply of breast milk substitute

Breastfeeding
If an HIV-positive mother chooses to breastfeed, she should do so exclusively. Exclusive breastfeeding helps to prevent diarrhoea and respiratory infections and is associated with the reduction of HIV transmission in comparison to mixed feeding. Partial breastfeeding mixed with artificial feeding increases the risks of both HIV and other infections. A woman who chooses to breastfeed needs help to ensure effective suckling and milk flow through good attachment (see Part 4) to prevent nipple damage and mastitis which can increase the risk of HIV transmission (see Part 7).

A mother may decide to stop breastfeeding around the age of six months if she is able to feed the baby safely in another way. It is less of a risk to stop breastfeeding a baby after the age of 6 months than in the first 6 months of life, but there are still difficulties, particularly in emergency settings. Therefore the UN recommends that

- at six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be regularly assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.

Wet nursing of orphans

Wet nursing means a woman breastfeeding another woman's baby. The practice of wet nursing should be reviewed in places where the prevalence of HIV is high. It may be discouraged if alternative methods of infant feeding, and the resources required, are fulfilling the AFASS conditions. Where AFASS conditions do not apply, however, wet-nursing may be considered in communities where this option is accepted. The wet-nurse must understand and agree to the implications of HIV testing and counselling, as she will need HIV testing before wet-nursing and 6–8 weeks after starting. In addition, she should be counselled about HIV infection and how to avoid infection during breastfeeding. There is anecdotal evidence of infected infants transmitting HIV to their HIV-negative breastfeeding mothers.

[3] WHO and UNICEF have published two longer course manuals titled Breastfeeding Counselling: a training course (WHO/CDR/93.4), and HIV and Infant Feeding Counselling: a training course (WHO/FCH/CAH/00.4). These teach counselling skills not covered by these brief IFE Modules, and provide additional visual materials.

2.4 Continuing assistance and social support

In an emergency, mothers may be at any stage of breastfeeding. Some may have difficulties due to lack of earlier attention, or to culturally accepted practices. These can be changed, as part of families' adaptation to the emergency situation, but not overnight.

Whenever breastfeeding is not going easily, help and care may be needed for several weeks to establish age-appropriate breastfeeding, the mother's confidence, and the baby's satisfactory growth. Help for breastfeeding needs to continue after the age of six months, when complementary foods are also given.

Women may easily lose confidence and doubt the adequacy of their breastmilk even in settled conditions. Mothers who are socially isolated find it even harder to care for their infants, and may have extra breastfeeding difficulties.
Health and nutrition workers can provide both supportive arrangements and personal attention to make breastfeeding easier.

Supportive arrangements

IFE 2/15

Supportive arrangements and personal attention **IFE 2/15**

- reduce isolation
- provide privacy if culturally required
- encourage age-appropriate feeding
- educate family and community members
- remove conflicting messages
- listen
- build confidence

Adapted from F. Savage, A Burgess - Nutrition for Developing Countries. 1993

Reduce isolation
- Arrange for breastfeeding women to meet together often, especially young, shy, first-time mothers, or women who have lost their families, communities or social networks.
- Home visits or seeing them at special times reduces the isolation of women who find it difficult to mix in a group.
- Provide privacy if culturally required.

Encourage age-appropriate feeding
- Support for mothers includes consistently encouraging them:
  - to breastfeed exclusively for six months, and
  - to continue breastfeeding frequently day and night up to two years or beyond, with adequate complementary foods.
- Praise mothers when they feed their babies like this, and make sure they understand that it is the best way to ensure a plentiful milk supply.

Educate family and community members
- Help families and community members to support age-appropriate feeding.
- Do not criticise women who are breastfeeding more exclusively, more frequently, or for longer than used to be customary.

- Explain the unique value to the health of the child and the mother of the new feeding pattern, throughout the emergency and beyond.

Remove harmful messages

- Remove any leaflets, posters or other messages that conflict with good breastfeeding practices, for example:
  - materials suggesting that other foods can replace breastmilk before the age of 12 months, or that breastfeeding frequency or night breastfeeds be reduced before a child is a year old.

Personal attention: listening and confidence-building

Health and nutrition workers should listen to and talk with mothers themselves when they can speak the mothers' language.
Additionally, you can arrange for community health workers to visit women at home, or for women to talk with each other in mother-support-groups (see Part 4).

Mothers are greatly helped to breastfeed and care for their infants if someone calm and friendly *listens* to them, and builds their confidence with reassurance and correct information.

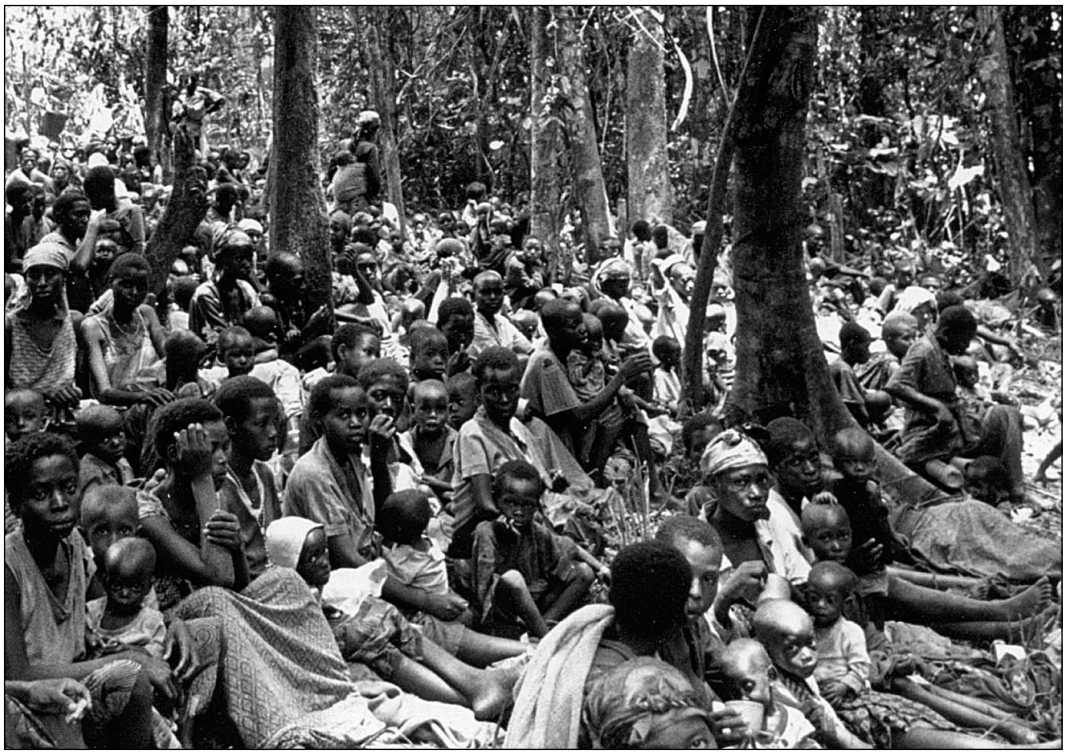
Listen

- Listening, and encouraging women to talk about their worries, confusion and grief, can be of great benefit.
- Where culturally appropriate, ask a mother about her family, her workload and how she is coping.
- Breastfeeding may be the least of her anxieties, if family members are missing.
- Alternatively, find someone else to sit quietly and listen and talk with the mother until she starts to tell of her concerns.

Build confidence

- A kind, approving and uncritical woman, who quietly listens to what a mother says, and praises what she does right, is reassuring and makes a mother feel more confident.
- The mother needs the encouragement of such a reassuring woman.
- This sort of encouragement helps a woman to believe that her milk will not stop even in an emergency setting and that any breastfeeding difficulties can be overcome.

3 Assessment of mother/child pair



Rwandan refugees in Central African rainforest, 1997. R. Chalassani for UNHCR

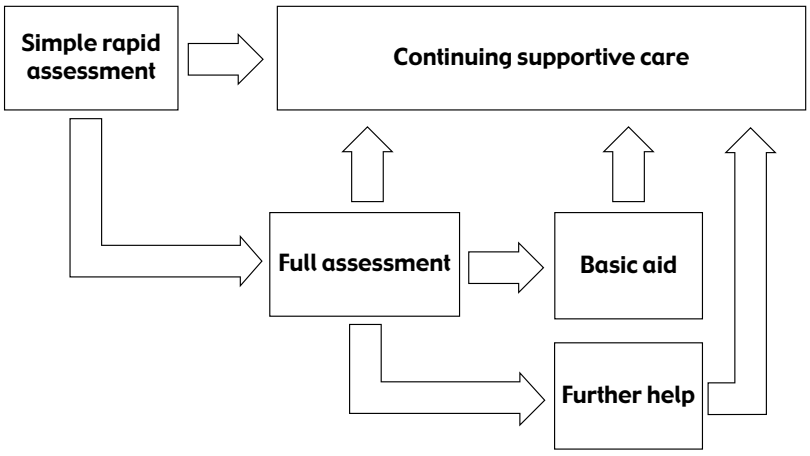
3.1 Two forms of assessment

You can use two methods to assess the feeding of children aged 0 – 2 years:

- Simple Rapid Assessment and
- Full Assessment

IFE 2/16

Deciding who needs help **IFE 2/16**



Simple Rapid Assessment (SRA)

SRA can take place at intake, registration, or any early meeting with health and nutrition workers. SRA decides whether:

- the baby is not at immediate risk of inadequate feeding, and the mother needs only supportive care (see Part 2), or
- the baby is at immediate risk of inadequate feeding, and should be referred for Full Assessment.

Full Assessment (FA)

This usually takes place in a health care setting, when a mother is referred there.

Full Assessment indicates:
- What needs to be improved
- What kind of help is needed.

All mothers should be receiving the supportive care described in Part 2. Two levels of additional help may be needed by breastfeeding mothers:

- **Basic Aid,** which many mothers may need (see Part 4.2), or
- **Further Help**, which a few may need (see Part 5.1).

Some caregivers may need help with **Artificial Feeding** (see Part 6).

Severely malnourished or ill mothers need immediate care for themselves. They should be referred without delay to appropriate services, with their infants. Full Assessment of infant feeding should be part of treatment within those services.

3.2 Simple Rapid Assessment (SRA)

Simple rapid assessment (SRA) does not require medical or nutrition training, or observation of breastfeeding. It covers:

- age-appropriate feeding
- breastfeeding ease
- the baby's condition.

Keep the SRA simple. IFE 2/17, 2/18 and 2/19 list the questions asked for SRA.
Try to memorise these questions, so that you can ask them without using a form. We give a form for practising, but, in the real situation, there is no need to keep a written record. It is best to question each woman away from other women as her responses may be affected if other women can hear her.

Age-appropriate feeding

IFE 2/17

Simple Rapid Assessment: Age-appropriate feeding **IFE 2/17**

Ask:
1. How old is the baby? Age _____months
2. Are you breastfeeding him/her?
3. Is the baby getting anything else to drink or eat?

Reasons to refer for Full Assessment:

- not breastfed
- breastfed but feeding not age-appropriate
  - under 6 months, not exclusively breastfed
  - over 6 months, and given no complementary foods

Ask:

1. How old is the baby? (If caregiver does not know, estimate: under or over six months.)
2. Are you breastfeeding him/her?
3. Is the baby getting anything else to drink or eat?

If infant:

- is not breastfed (whether under or over six months old)
- is breastfed, but feeding is not age-appropriate *(under six months and not exclusively breastfed, or over six months and given no complementary foods)*, the infant is at risk of inadequate feeding.

Refer for Full Assessment.

All infants who are artificially fed should be referred for Full Assessment.
They are at high risk in an emergency setting.

Breastfeeding ease

IFE 2/18

SRA: Breasting ease **IFE 2/18**

Ask:

4. Is the baby able to suckle the breast?
5. Have you any other difficulties with breastfeeding?

Reasons to refer for Full Assessment:

- baby not able to suckle
- mother has other difficulties with breastfeeding
- mother requests breastmilk substitutes

Ask:

4. Is the baby able to suckle the breast?
5. Have you any difficulties with breastfeeding?

Let the mother talk as freely as she wishes about how she is feeding. But she may answer only briefly.

If the mother says that:

- the baby cannot suckle
- she has other difficulties with breastfeeding
- she needs breastmilk substitutes.

the baby is at risk, refer for Full Assessment.

IFE 2/19 Baby's condition

Looking at the baby´s condition **IFE 2/19**

Look:

6. Does the baby look very thin?
7. Is the baby lethargic, perhaps ill?

Reasons to refer for Full Assessment:

- looks very thin
- lethargic, perhaps ill

Ask the mother or caregiver to unwrap the baby - at least enough for you to see the face and upper body - and ask her to try to wake the baby.

Look:

6. Does the baby look very thin?
7. Is the baby lethargic, perhaps ill?

If the baby is sleeping soundly, you can ask the mother or caregiver what the baby is like while awake. She can tell you if the baby is not behaving in the usual way.
If the infant:

- is visibly thin, or
- is lethargic, perhaps ill,

refer for Full Assessment, and possible medical care.

Finishing SRA

If the infant is not at immediate risk because feeding is age-appropriate, breastfeeding is easy, the baby can suckle and is not visibly thin or lethargic and the mother needs only supportive care:

- praise the mother and tell her she is doing well in these difficult circumstances
- tell her where to go for support and help with breastfeeding, if she wants it.

If the infant is at immediate risk for any of the above reasons, and Full Assessment is needed:

- explain to the mother where she should go.

Practice form: Simple Rapid Assessment

Ask:
1. How old is the baby? Age _____
2. Are you breastfeeding him/her?
3. Is the baby getting anything else to drink or eat?
4. Is the baby able to suckle the breast?
5. Have you any difficulties with breastfeeding?

Look:
6. Does the baby look visibly thin?
7. Is the baby lethargic, perhaps ill?

Reasons to refer for Full Assessment:
____Not breastfed
____Breastfed but feeding not age-appropriate
under 6 months, not exclusively breastfed
over 6 months, and given no complementary foods
____Baby unable to suckle the breast
____Mother has other difficulties with breastfeeding
____Mother requests breastmilk substitutes
____Baby visibly thin
____Baby lethargic, perhaps ill

Practising Simple Rapid Assessment

Use the SRA practice form with a colleague until the questions are easy to ask. Then try the SRA with several women and babies, wherever you are, whether or not you are in an emergency setting.
After a time, you will remember the questions and things to look for. Then you will need only a minute or two with each mother and baby.

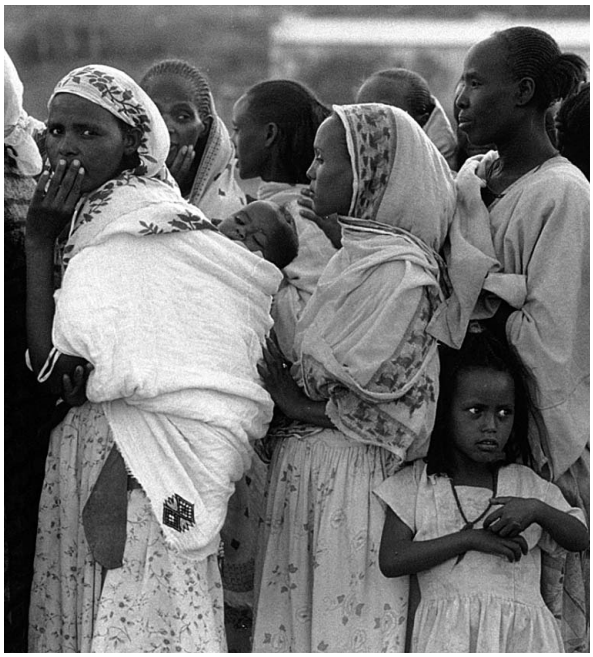
Keep the SRA simple. Remember you do not need full details of feeding at this stage and you should not give advice yet.

Exercise: SRA (photographs)

We have used real photos from emergencies to illustrate possible situations and made up typical details. What would you do for each situation?

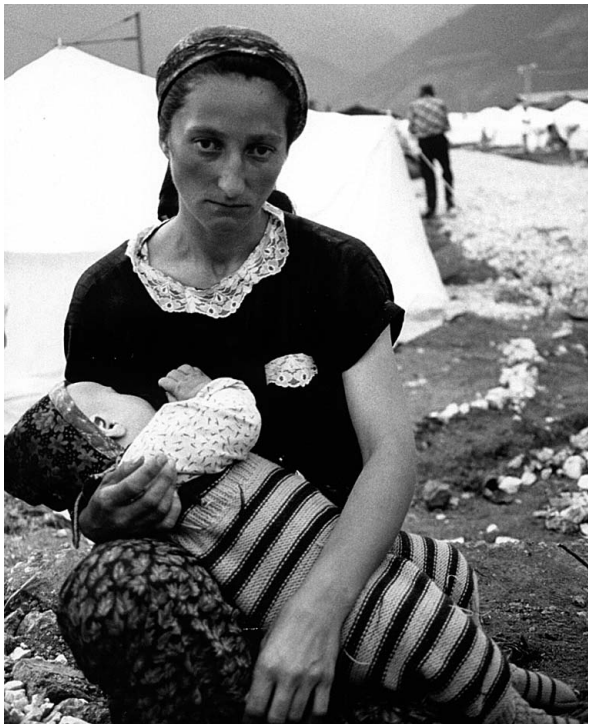
1. Women waiting to register, Dubarwa, Eritrea (2000)

Suppose this baby is three months old, and the mother says she breastfeeds him exclusively. As the mother unwraps him, he stirs, opens his eyes, and looks around. His chest and arms do not look thin.
The mother tells you that breastfeeding is going well, although she is worried about her missing older son.



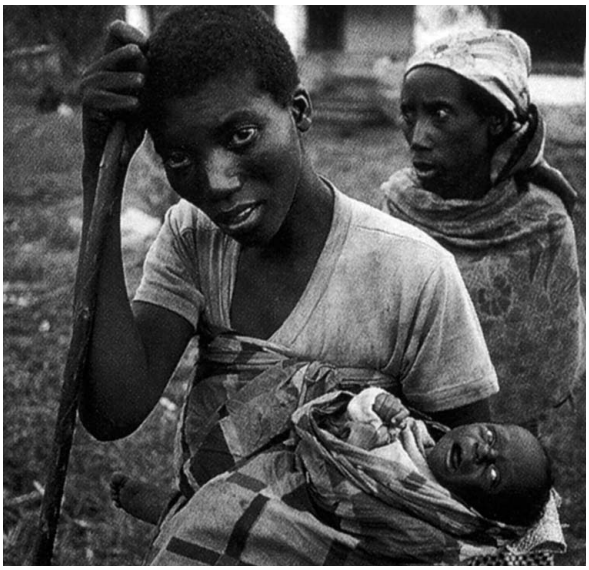
2. Discouraged mother, Kladanj, Bosnia (1995)

This mother is breastfeeding her nine month old daughter and also feeding her cereal. The child is growing very well, but the mother is sure that her milk is going away because of the stress of having to flee from her city. She has lost almost everything, and fears losing her breastmilk as well. She asks to be given infant formula for her child.



3. Mother and child arriving in Biaro, Congo (1997)

This very malnourished and dehydrated mother has walked more than a hundred miles through the rain forest to get help for herself and her baby. She says that all she has been able to do is to breastfeed. The baby is four months old and looks thin. He is irritable and limp, and is not suckling much. The mother believes that her son is rejecting the breast because she is too ill to breastfeed.



Answers

1. Mother in Eritrea
Do not refer, as the baby is exclusively breastfed, looks as if he is growing well, and the mother is not concerned about infant feeding. Supportive care from the health services in the next few weeks should be enough.

2. Mother in Bosnia
Refer for Full Assessment, because of the mother's doubts about her milk production.

3. Mother in Congo
Provide drinking water and food immediately, then refer them together to appropriate medical care and possible therapeutic feeding.

3.3 Full Assessment (FA) of infant feeding

Full Assessment (FA) is generally done by health or nutrition workers with direct responsibility for mothers' and babies' health and nutrition.

If mothers do not want male workers to watch them breastfeeding, it is urgent to identify female workers who can carry out Full Assessment.

Full Assessment helps health and nutrition workers to know:

- if the baby is suckling effectively
- if the mother feels confident and her milk is flowing
- if her milk production is adequate
- more details about age-appropriate feeding.

Full Assessment of infant feeding has three Steps:

1. Observing a breastfeed if the child is breastfed.
2. Listening and learning from the mother or caregiver in all cases.
3. Observing artificial feeding if the child is artificially fed. This step is covered in Part 9.10.

Providing the health and nutrition workers with laminated copies of the Full Assessment practice forms helps them to carry out these Steps.

Ask: Is the child breastfed?

If the child is breastfed, observe a breastfeed (Step 1). This identifies causes of "not enough milk" that the mother herself may not have recognised, such as ineffective suckling or very short feeds.

If the child is *not* breastfed, use only Steps 2 and 3 of the Full Assessment (see also Part 9.10).

Full Assessment (FA) Step 1: Observing a breastfeed

If the infant has not breastfed recently, ask the mother to put her baby to the breast.
If the mother says that the baby is not willing to breastfeed at this time, because s/he has fed recently, ask her to wait nearby and tell you when the baby is ready to breastfeed.
Observe the breastfeed for at least four minutes, and preferably until the baby comes off the breast by him/herself. Listen to and talk with the mother casually, using the Step 2 Listening and Learning topics (see below), or on any other topic.
Meanwhile, quietly notice how she manages the breastfeed. Give no advice or help.

As you observe the breastfeed watch for four things:

1. Attachment to the breast.
2. Effectiveness of suckling.
3. Mother's confidence.
4. How the feed ends.

Observing and listening without giving advice may be difficult to do at first.

However, these are important skills for helping mothers and caregivers.

If the infant is unable to suckle at the breast at all, or does so only weakly (and this is not because of a recent feed), refer for medical assessment, or to a Therapeutic Feeding Centre. The infant may be ill or malnourished.

Look for good attachment

- First check the baby's attachment at the breast.
- A baby needs to be well attached to suckle effectively.
- Remember the four signs of good attachment (see p 9):

  - areola (more above)
  - mouth (wide open)
  - lower lip (turned out)
  - chin (touching breast).

If a baby is very close to the breast, it may be difficult to see if the *lower lip is turned outwards*. If an older infant is suckling on a pointed breast, *the chin may not touch the breast*. Otherwise, **if any one of the signs is not there, the baby is poorly attached.**
If the mother has pain or discomfort of her nipples, that too usually means poor attachment.

IFE 2/20

Full assessment Step 1: Observing a breastfeed **IFE 2/20**

- **Attachment**
  - areola, more above
  - mouth wide open
  - lower lip turned out
  - chin close to or touching breast
  - no nipple pain or discomfort
- **Suckling**
  - slow, deep sucks, sometimes pausing
  - audible or visible swallowing
- **Mother confident**
  - enjoyment, relaxation (not shaking breast or baby)
  - signs of bonding (stroking, eye contact, close gentle holding
- **How the feed ends**
  - baby comes off the breast by itself (not taken off by mother)
  - baby looks relaxed and satisfied, and loses interest in the breast
  - mother keeps the breast available, or offers the other breast

Check the baby´s suckling

- Notice signs of effective suckling
  - slow, deep sucks, sometimes pausing
  - audible or visible swallowing.

These are signs that the baby is suckling effectively and getting breastmilk easily.

- Notice signs of ineffective suckling
  - rapid sucks, with smacking sounds
  - fussing at the breast
  - coming on and off the breast.

These are signs that the baby is not getting the milk easily.
The mother may say that the baby is feeding very frequently or for a very long time, and/or is very restless and unhappy after feeds. These are also signs that the baby is not getting the milk easily.

Notice whether the mother seems confident

Does she seem to be enjoying breastfeeding and is she relaxed and happy with the baby? She may show signs of bonding (strong, close, loving feelings) with the baby, such as stroking or eye contact, but these gestures are not universal. She may show little emotion, yet gently hold her infant closely and confidently.

A mother who is shaking her breast or shaking the baby during a feed is showing that she is not relaxed. She may also keep shaking her leg, tapping the baby's cheeks, or moving the baby repeatedly from one breast to the other.

Effective suckling and a confident, relaxed mother are signs that breastmilk is flowing well.

Notice if the mother shows pain while breastfeeding

Ask her if she has pain or discomfort in her breasts or nipples.
However, during the assessment the mother may tell you, or you may observe, that she has pain or swelling or some other concern about the condition of her breasts.
Possible causes of breast pain and swelling and how to help the mother are discussed in Part 7.
Pain or discomfort without other signs is often cured by Basic Aid for breastfeeding (see Part 4).

It is important to understand that you do not reach any conclusions about the production or flow of milk from the appearance of the breast.

Watch how the feed ends

Ideally, every breastfeed continues, with a few pauses and minutes off the breast, until the baby spontaneously stops and releases the breast.

Notice which of these happens:

- The baby comes off the breast by him/herself and loses interest in the breast. The baby may look relaxed and satisfied and is not immediately restless and unhappy.
  This indicates that the baby has had all the milk s/he needs, including hindmilk.

- The mother keeps the breast available, or offers the other breast.
  This indicates that she is not restricting the feeds, but allowing the baby to continue if s/he wants to.

- The mother takes the baby off the breast herself, and tucks her breast away.
  This indicates that the mother is restricting the length of feeds, and the baby may not have had all the milk that s/he needs.

Practice form for Full Assessment
Step 1: Observing a breastfeed

(Ask whether the child is breastfed. If not, use Full Assessment Steps 2 and 3.)

Observe the breastfeed for at least four minutes, and preferably until it ends.
Give no advice or help. You can mark Yes or No, or make other notes.

If all answers are "yes", it indicates that breastfeeding is going well. If some of the answers are "no" the mother needs help.

Attachment at breast	___ areola, more above
	___ mouth wide open
	___ lower lip turned out
	___ chin close to or touching breast
	___ no nipple pain or discomfort
Suckling	___ slow, deep sucks, sometimes pausing
	___ audible or visible swallowing
Mother confident	___ enjoyment, relaxation, not shaking breast or baby
	___ signs of bonding (stroking, eye contact, close gentle holding)
How the feed ends	___ baby comes off the breast by himself (not taken off)
	___ baby looks relaxed and satisfied and loses interest in the breast.
	___ mother keeps the breast available, or offers the other breast.

Practice of Full Assessment Step 1: Observing a breastfeed

Use a copy of the Full Assessment Step 1 form above to learn what to look for.
Take every opportunity to observe breastfeeds from start to finish.
If possible, observe with a colleague, then move away and compare observations.

Full Assessment Step 2: Listening and learning

When you are doing a Full Assessment and helping a mother or caregiver, one of the most important things to do is to listen to her attentively, and to learn from her.
What you learn from her can help you to give her the support that she needs and in particular to:

- build or restore her confidence, and
- increase her milk production.

It will also tell you whether, and how, she feeds other milk and foods, so you can:

- guide her about age-appropriate feeding for her child.

Paying attention

Introduce yourself and ask the mother's permission to talk to her. Stand or sit on the same level as her. Show by your body language (e.g. facing her and looking interested) and by your responses that you are paying full attention to what a mother says, and that you hear, understand and remember what she says.

Encouraging a woman to talk freely

A useful way to encourage a person to say more is to ask open questions.
These start with words like "what" and "how?"
You can also invite a mother to talk freely with open questions like "Could you tell me about…?"

Practise putting the following open questions and invitations to talk into the local language:

"How are things going with the feeding?"
"Could you tell me how the feeding is going?"
"Would you like to tell me about how you are feeding?"

This kind of question tells you more, and is less discouraging to the mother, than asking whether she has problems.

Working through interpreters

Health and nutrition workers who must rely upon interpreters may need to discuss with them how to talk with mothers gently about breastfeeding, and how to transmit the mother's replies

precisely. Interpreters may sometimes translate an open question such as "How is feeding going for you and the baby?" into a less helpful form such as "Do you have any problems with infant feeding?" or even an authoritative "You know how to breastfeed, don't you?"

They may also have a custom of shortening and summarising replies. This can transform the mother's "I am worried about whether I will have enough milk, because I haven't eaten enough" into the interpreter's "She doesn't have enough milk." Explain to an interpreter why you need to know the details of what a woman is saying.

Learning from the mother or caregiver

This section summarises the topics to cover when learning from the mother or caregiver. But it cannot show how to ask open questions, listen attentively and be sensitive to each woman in accord with her culture and her feelings. The topics you need to learn about are:

- how the child is breastfed
- what other foods and drinks are given
- the mothers beliefs and worries about infant feeding
- how the mother is feeling
- whether she is interested in increasing her breastmilk.

The following are questions to ask the mother or caregiver in order to learn how the child is breastfeeding. Do not give advice or corrections untill you have full information.

Learn how the child is fed – breastfeeding

If breastfeeding has not yet been observed:
Ask:
- Is the baby breastfeeding?

If breastfeeding has already been observed, or the mother says yes to the first question:
Ask:
- About how often is the baby breastfed in a day? during the night?
  - In the day, does she keep the baby with her?
  - Does she sleep with the baby?
- If she says demand feeding, what exactly does this mean:
  - Every time the infant cries?
  - Before s/he cries?
  - Only if s/he cries a lot?
  - About how often is that?

In some settings, you will also want to know:
- Is the baby given a pacifier (dummy, soother, whatever is given to baby to suck)?

IFE 2/21

Full assessment Step 2 **IFE 2/21**

Listening and learning

Breastfeeding? ___yes ___no How often by day?_____ by night?_____
Using a pacifier? ___yes ___no

Other drinks and foods? ___yes ___no
What drinks? _____ How given? _____
How many times a day? _____
What sort of family foods? _____
How many times a day? _____

Beliefs and worries about feeding; how mother/caregiver decided
_____
_____

How is mother/caregiver physically and emotionally?
_____
_____

Interest in increasing breastmilk or relactation ___yes ___no

This transparency summarizes the topics to cover in learning from the mother or caregiver. But it cannot show how to ask open questions, to listen attentively and to be sensitive to each woman in accord with her culture and her feelings.

Learn how the child is fed – other drinks and foods

Ask:
- Is the baby getting other drinks or foods?
- What drinks is s/he given?
- How are the drinks given?
  - Is it by spoon, cup, hand, feeding bottle, other technique?
- How many times a day?
- What soft or family foods is the child eating?
- How many times a day?

Provide a list of local foods, drinks, and feeding techniques, if this will help the discussion.

Learn about the mother´s or caregiver's beliefs and worries about infant feeding

You need to learn whether she already knows about breastfeeding and its value, and whether she has any beliefs and worries that affect how she feeds.

Ask (respectfully):
- What made you decide to feed as you are doing?
- What have people told you about infant feeding?

Do not disagree with or correct any misconceptions immediately, as that will stop her talking freely.
Learn if she has any beliefs, fears, doubts or misconceptions that make her worry about breastfeeding.
People may have told her that she is too stressed to breastfeed.

Learn how the mother or caregiver is feeling, both physically and emotionally

- She may be malnourished, ill, or exhausted. (She will need urgent treatment.)
- She is likely to have lost her home and familiar community.
- She may be mourning dead family members, or worrying about missing children.
- She may be suffering from depression and the aftermath of traumatic stress.
- She may reject a baby resulting from rape, or because torture and terror have robbed her of a sense of human connection.

Ask (adapted as culturally appropriate):
- How are you yourself?
- Is there anything worrying you that you would like to talk about?

If she can talk, it may help to release some feelings. However, she may not want to talk. Do not press her, but try to provide the warmth and companionship that will in time allow her to speak to you or others.

Learn about her interest in increasing her breastmilk (or in relactation).

If the mother is breastfeeding but concerned about her milk production:
Ask:
- Would you like to increase your breastmilk? We can help you to make more.

If the mother or female caregiver is not breastfeeding,
Ask:
- Would you be interested in breastfeeding this baby? We can help you to produce breastmilk again.

Practice of Full Assessment (FA) Step 2 – asking questions

Practise Step 2 with a colleague. One takes the role of health worker, the other takes the role of the mother or caregiver.

First use the form below. Adapt the questions to the local culture, if it seems necessary. Use the language you will speak with mothers, if possible.

Practice form for Full Assessment (FA)
Step 2 - asking questions

- Is the baby breastfeeding?
- About how often is the baby breastfed in a day? During the night?
  - In the day, does she keep the baby with her? Does she sleep with the baby?
  - If she says demand feeding, what exactly does this mean: every time the
  - infant cries? Before s/he cries? Only if s/he cries a lot? About how often is that?
- Is the baby given a pacifier (dummy, soother, whatever is given to baby to suck)?
- Is the baby getting other drinks or foods?
- What drinks is s/he given?
- How are the drinks given?
  - Is it by spoon, cup, hand, feeding bottle, other technique?
- How many times a day?
- What soft or family foods is the child eating?
- How many times a day?
- What made you decide to feed as you are doing?
- What have people told you about infant feeding?
- How are you yourself?
- Is there anything worrying you that you would like to talk about?
- Would you like to increase your breastmilk? (We can help you to make more.)
- Would you be interested in breastfeeding this baby? (We can help you to produce breastmilk again.)

Remember not to give advice or corrections during this step.

Practice of FA Step 2 – recording responses

Use the recording form below. Write brief notes on the form.
Keep your practice notes to use in Part 4.

Practice form for Full Assessment (FA)
Step 2 - recording responses

Breastfeeding? yes ___ no ___
How often by day? _____ by night? _____
Pacifier? yes ___ no ___

Other drinks and foods? yes ___ no ___
What drinks? _____
How given? _____
How many times a day? _____
What soft or family foods? _____
How many times a day? _____

Mother's beliefs, how she decided feeding
_____
_____

How is mother/caregiver physically/emotionally? Any worries?
_____
_____

Interest in increasing breastmilk or relactation yes ___ no ___

Practicing Steps 1 and 2 with mothers and caregivers

When you are at ease with the questions, practise both Steps 1 and 2 of the Full Assessment with mothers and caregivers.
You will find that you can often combine observing a breastfeed (FA Step 1) with listening to and learning from the mother (FA Step 2).
If a mother or caregiver is not breastfeeding, practice with FA Step 2 only to learn how she feeds the infant.

You may take brief notes if that does not make the mother uneasy. Alternatively, remember carefully what she says, and record it later.

Keep your practice notes to use in Part 4. Step 3 of the Full Assessment is described in Part 9.10.

4 Providing help to improve infant feeding

4.1 Deciding what help is needed[1]

After making a Full Assessment, the health or nutrition worker needs to decide how to help the mother and baby.

All mothers should be getting supportive care for breastfeeding, integrated into general assistance, and health and nutrition care. Mothers with any of the common difficulties, and most who are not giving the baby age-appropriate feeding, can be helped by a package of simple care that we call Basic Aid for breastfeeding.

In addition to Basic Aid, some mothers also need more skilled interventions, which may include Further Help for breastfeeding, help with artificial feeding options (e.g. temporary or longer term supplements, when appropriate), therapeutic feeding, or medical treatment.

We summarise the indications for the different levels of help in the following two tables.

Levels of help for infant feeding: conditions needing Basic Aid for breastfeeding
Mother and infant are adequately healthy but assessment shows:
• mother lacks confidence • misconceptions, worries about breastfeeding • doubts about having adequate breastmilk • requests for breastmilk substitutes to supplement breastfeeding • interest in increasing breastmilk
• poor attachment or ineffective suckling • discomfort or mild pain from nipples • normal fullness of breasts after birth
feeding not age-appropriate • under 6 months: - gives other drinks or foods - breastfeeds <8 times/day - no night breastfeeds - mother ends feed, puts breast away
• 6-12 months - breastfeeds <6 times/day - no complementary foods - foods less than 3 times/day
• 12-24 months - no complementary foods - foods less than 3 times/day

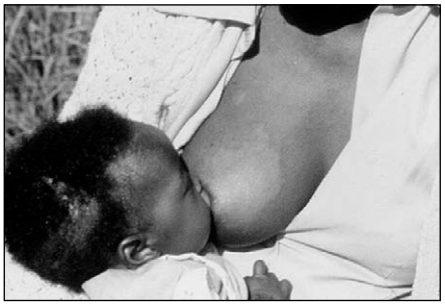
[1] The general conditions to support breastfeeding in a population, such as providing an adequate diet, are discussed in Module 1 and in Module 2 Part 2, and are not repeated here.

Levels of help for infant feeding: conditions needing more skilled help	
Assessment shows:	**Appropriate help:**
• mother malnourished or ill • infant severely malnourished: - very thin or oedematous (swollen with fluid) • infant unable to suckle, lethargic, perhaps ill	• refer urgently for: - medical treatment - therapeutic feeding • when in hospital or therapeutic feeding centre, provide: - full assessment - Basic Aid - Further Help with breastfeeding (including relactation) - artificial feeding options (temporary supplementary feeding)
• mother traumatised, in emotional crisis, rejecting infant	• provide: - Further Help (restorative care) - Basic Aid
• infant visibly thin or underweight (mild or moderate malnutrition) • infant refusing to suckle, but not lethargic or ill	• provide: - Full Assessment - Basic Aid - Further Help (to get baby to suckle again; to increase milk production) - artificial feeding options (temporary supplementary feeding) • if over six months, also provide: - improved complementary feeding
• not breastfeeding	• offer: - Further Help (relactation - if mother /caregiver interested) • if no possibility of relactation, offer: - artificial feeding options
• difficulty attaching to breast with flat nipples	• provide: - Basic Aid - Further Help (to attach baby, feed expressed breastmilk while learning)
• inverted or very large nipples • severe or persistent nipple pain • breast pain, swelling or other breast conditions (engorgement, blocked duct, mastitis)	• provide: - medical care - other help described in breast conditions

IFE 2/22

Appropriate help restores breastfeeding and growth **IFE 2/22**

Ella at four weeks



Ella at four months

Source: Felicity Savage

Case study: Appropriate help restores breastfeeding and growth

Ella, the infant shown in both pictures on the overhead figure (IFE 2/22), came into a clinic when she was four weeks old. She was visibly thin and weighed only 2 kg.

- What can you see in the left-hand picture that might explain why she was thin?*

At birth, Ella was given bottle feeds to 'supplement' breastmilk, and when she went home she was not suckling effectively. As well as breastfeeding, her mother gave her about 200 ml of cow's milk each day, diluted and fed by bottle. When she came to the clinic, her mother said Ella was not breastfeeding well, and often refused the breast.

Fortunately, Ella was not sick. However, as the family lived far away from the hospital, she and her mother were admitted to hospital and kept together with frequent skin-to-skin contact. The health worker showed the mother how to help Ella to attach better to the breast, so that she could suckle effectively. The mother also learned to express her milk every three hours and feed it to Ella with a cup until she was suckling better and taking long feeds.

The health worker listened to the mother, tried to build her confidence, and encouraged her to breastfeed as much as possible to increase her milk production. Ella needed a few supplementary cup feeds of formula in the first two days. But these became unnecessary and with continued encouragement, Ella started exclusive breastfeeding.

The second photograph shows Ella at four months, well attached, suckling effectively, and still breastfeeding exclusively. She then weighed 4.5 kg, an average gain of almost 28 g/day.

Source: F. Savage

***Answer**: The picture shows that her mouth is not wide open, her lips are pointing forward, and her chin is far from the breast, so she is poorly attached. If a baby is poorly attached she cannot suckle effectively. Ella also looks very anxious and tense, and her cheeks are drawn in as she tries to suckle.

Practice in deciding the appropriate level of help

Use the Levels of Help tables above, and the notes you wrote when you were practising Full Assessment, Step 1 (See p 35) and Step 2 (See p 38).
On your own or with a colleague, consider what level of help would be appropriate in each of the situations that you examined.

In most situations, it is not necessary to stop breastfeeding. With appropriate help and support the mother can in many cases continue to breastfeed, or if she has stopped, she can resume breastfeeding.

4.2 Basic Aid for breastfeeding

Basic Aid for breastfeeding includes the simple, essential interventions to prevent and resolve the most common difficulties. Basic Aid can also help with some less common difficulties.

Basic Aid has four steps :

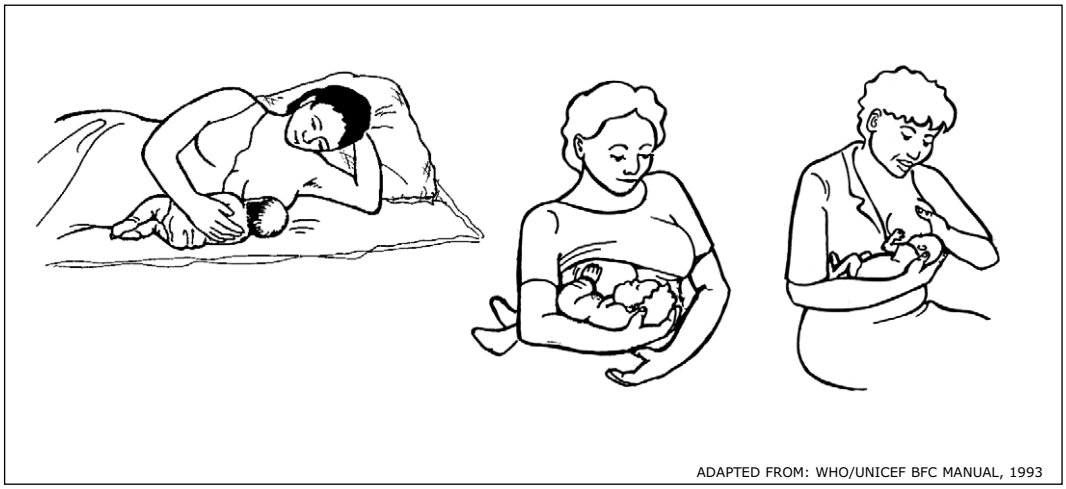
Step 1: Ensure effective suckling.
Step 2: Build the mother's confidence and help milk flow.
Step 3: Increase milk production.
Step 4: Encourage age-appropriate feeding.

Step 1: Ensure effective suckling

First, observe a breastfeed. If the attachment is good and the baby suckling effectively, you do not need to make any changes. Praise the mother and move on to Step 2.

If you think the attachment is poor, and the suckling ineffective, help the mother to improve it, as you learnt in Part 1. To improve attachment, you may need to change the position of the baby's body. Remember that it should be straight, facing the breast, close and supported.

Possible ways to make it easier for the mother to attach her baby to her breast are:
- You can arrange to support the mother's back if she is sitting without support.
- She can lie down.
- She can hold the baby under her arm.
- She can hold the baby with the opposite arm, to support the baby more easily. (This is particularly helpful for very small babies.)



ADAPTED FROM: WHO/UNICEF BFC MANUAL, 1993

Alternative positions for good attachment

- If the baby has many wrappings and they get in the way, the mother can open them up so that she can hold the baby closer. Show her how to arrange the wrappings in a way that keeps the baby warm, but does not keep the baby away from the breast.
- If a mother holds the breast very close to the nipple her fingers can get in the baby's way, you can show her how to support the breast with her fingers further back, and not pinching.

Distraction by noise and activity can make some babies suckle less effectively. Sometimes the mother has a habit of patting the baby's cheeks, or shaking the breast or baby. These may also disturb suckling.

- Try to avoid conditions that distract the baby, and let the baby suckle at his/her own speed.
- Remove interference with suckling: avoid pacifiers and feeding bottles.

Step 2 : Build the mother's confidence and help milk flow

Effective suckling (Step 1) helps a woman's milk to flow.
But in addition encourage her to:

- Have plenty of skin-to-skin contact with her baby.
- Take pleasure in her baby, by playing and looking at him or her, face to face.

This helps the release of hormones, especially oxytocin, and the flow of her milk.
It can also calm and comfort a woman under stress.

In addition, a mother needs to feel confident that her milk is adequate.

You can help to *build her confidence* when you talk with her if you use a friendly, reassuring manner, and do not criticise her or give her instructions:

- *Recognise and praise* what she and her baby are doing right. Praise her for continuing to breastfeed, and for her baby's growth, or whatever else is going well. Praise the baby's effective suckling and swallowing, and any other signs of milk flow. Help her to recognize and welcome these signs.

- *Give her relevant information* in an encouraging way that builds her confidence. Good information can help to reassure her, reduce her worries, and correct misconceptions. For example, help her to understand that her milk is always the best food, even if she is upset or has a very simple diet, and that she can have enough for her baby.

Help to reduce some of the stresses of the emergency for her by providing an atmosphere of security, warmth, and reassurance. Help a mother to find companions whom she can trust, such as other breastfeeding mothers, or reassuring older women, and to breastfeed near them. This may help her to relax.

IFE 2/23

Basic aid for breastfeeding **IFE 2/23**

Step 1. Ensure effective suckling

- improve attachment
- help with positioning, if necessary
- avoid distractions
- remove interference with suckling (bottles, pacifiers)

Step 2. Build the mother's confidence and help milk flow

- encourage skin-to-skin contact, face-to-face interaction
- have a reassuring, friendly manner, without criticism or commands
- praise what mother and baby are doing well
- give her relevant information in an encouraging way
- try to find warm companionship for her

Step 3: Increase milk production

You can help a mother increase the amount of milk she produces when:

- the baby attaches well and suckles effectively
- you have built the mother's confidence and helped her with her milk flow.

A mother can almost always increase her milk supply at any stage of lactation, right through the second year or beyond, if she improves her breastfeeding pattern.

Then the mother can also follow a **breastfeeding pattern** that encourages milk production. This means:

- Letting the baby suckle frequently.
- Letting the baby suckle longer at each feed.
- Making sure that the mother has enough water to satisfy her thirst.
- Removing anything that interferes with breastmilk production.

Let the baby suckle frequently

- The mother needs to let the baby breastfeed as often as s/he shows signs of hunger or asks for the breast. This should be a minimum of 8 times in 24 hours, but should, if possible, be 10, 12 or more times. (To increase her milk production, she should wake the baby and offer the breast if the baby is too sleepy to demand a feed, at least every three hours, and preferably much more often.)
- The baby can suckle for comfort too, at any time. Do not give a pacifier, only the breast.
- The mother should keep the baby with her as much as possible during the day, including in queues, and avoid long periods of separation.
- The mother should sleep with the baby and breastfeed at night.

Let the baby suckle longer at each feed

- The mother should let the baby suckle for as long as s/he is interested, pausing if the baby wants to, until s/he finishes and releases the breast by him or herself.
- The mother should avoid interrupting/stopping a breastfeed by detaching/taking the baby off the breast or putting the breast away the first time the baby pauses, or looks around.
- The mother should offer the second breast, and let the baby decide if s/he wants it, or if one was enough.

Help the mother to have enough water to drink

- Ensure the mother can keep enough drinking water available for herself, especially in hot or dry conditions.
- Supportive care (see Part 2) should already have assured that the mother is getting adequate food.

Remove anything that *interferes* with breastmilk production

- Reduce any milk supplements that the baby is getting by 50 ml/day. Breastmilk will increase each day until:
  - a baby who is aged under six months is exclusively breastfed, or
  - a child who is aged over six months is getting much more breastmilk than before.

- Advise the mother to avoid:
  - being separated from her baby
  - feeding to a schedule
  - other people caring for her baby
  - anything that delays breastfeeds
  - using feeding bottles and pacifiers, as already mentioned in Step 1.

- Prevent a new pregnancy. Offer non-oestrogen family planning methods throughout the first and second year.

'Insufficient milk' is not an appropriate reason to stop breastfeeding. It is a reason to breastfeed more, to increase production of breastmilk.

Step 4: Encourage age-appropriate feeding

Infants under six months old should have only breastmilk. The aim is to help mothers to increase their milk supply sufficiently so they exclusively breastfeed. Most women should be able to do this.

Infants of six months and older should have plenty of breastmilk and good complementary foods. Breastmilk can provide half or more of the child's nutrient needs. Complementary foods should be nutrient rich, and given 2-3 times a day at 6-8 months, and 3-4 times a day at 9-24 months with 1-2 snacks a day as desired (see Annex 11). Some kind of milk, such as full fat animal milk, may be one of the complementary foods. It can be mixed into other foods or given as a drink from a cup, not by bottle.

IFE 2/24

Age-appropriate feeding **IFE 2/24**

includes starting complementary foods when the child is ready/at the age of 6 months

Brian Gleeson, CRS Angola

From six months to two years of age, children should receive appropriate complementary foods in addition to continued frequent breastfeeding.

IFE 2/25

Basic aid for breastfeeding **IFE 2/25**

Step 3. Increase milk production

- Encourage the mother to let the baby suckle frequently.
- Explain how to let the baby suckle longer at each feed.
- Help the mother to get enough water to drink. (Supportive care assures mother gets enough food.)
- Remove any interference; reduce supplements by 30-60 ml/day.

Step 4. Encourage age-appropriate feeding

- If necessary help the mother to re-establish exclusive breastfeeding until the baby is six months old.
- If milk supplements are needed, teach her to give them by cup, not bottle.
- Show her how to prepare and give adequate complementary foods from six months of age.

Avoiding bottles when milk supplements are needed

In some populations, bottle feeding may be a customary and accepted way of infant feeding and difficult to stop.
Try to get everyone to understand that feeding bottles are not a good or necessary method of feeding milk or any other drinks. They are not a good way to feed newborns and infants who are too ill to suckle. Babies who bottle feed may become unwilling to suckle the breast effectively (see Module 1, p 54).

Cups are preferable and safer, especially in places where hygiene is difficult. Cups are easier to clean and can be used from birth onward, even for low birth weight babies. So teach caregivers how to cup feed if it is necessary to give supplements (see Annex 2).

IFE 2/26

Supplementing with a cup IFE 2/26

If an infant can
- suck (or lap milk with the tongue) and
- swallow,

he or she can be fed with any open cup.

Adapted from UNICEF BFHI News

Use of feeding bottles increases risks of illness.

IFE 2/27

Cup feeding technique IFE 2/27

F. Salvage / Philippines & UK

The milk just reaches the infant's lips.
The caregiver does not pour the milk into the baby's mouth.
The infant takes up the milk with his/her tongue, sucks or sips.

Practice giving Basic Aid for breastfeeding

Practise giving 'Basic Aid for breastfeeding' using the summary sheet below.
First, role-play with colleagues and then, with mothers.
Focus your practice on the commonest conditions, such as "not enough milk" or feeding that is not age-appropriate.

Basic Aid for breastfeeding
Summary

Step 1: Ensure effective suckling

- Observe a breastfeed for the 4 points of good attachment (areola, mouth, lip, chin) and effective suckling.
- If attachment is not good or suckling not effective, improve position (straight, facing, close, supported) and help attach the baby. If necessary, also improve the position by:
  - reducing baby's wrappings so s/he can reach breast
  - showing the mother how to hold her breast well behind the nipple, without pinching
  - encouraging her to lie down, hold the baby under arm, or across the body.
- Avoid distractions and let baby suckle at own speed.
- Avoid feeding bottles and pacifiers.

Step 2: Build the mother's confidence and help milk flow

- Help mother and infant until suckling is effective.
- Encourage her to enjoy skin-to-skin contact and to play with her baby face-to-face.
- Build her confidence:
  - recognise and praise what she is doing right – including signs of milk flow,
  - give relevant information in an encouraging way and correct misconceptions.
- Help her to breastfeed near trusted companions, which helps relaxation.

Step 3: Increase milk production

Encourage more frequent breastfeeds
- Ask mother to breastfeed very often, 12 times or more in 24 hours if the baby is willing.
- Tell her the value of keeping the baby with her day and night and breastfeeding at night.
- Encourage her to give the breast for comfort at any time.
- If baby is ill or unusually sleepy, encourage her to wake him/her up and offer her breast often.

Encourage longer breastfeeds
- Suggest that the mother continues each feed until baby stops him or herself and does not want more. It is best if she does not detach the baby or put her breast away quickly.
- Encourage her to offer the other breast, and let baby decide if s/he wants more or not.

Ensure mother gets enough to drink (Supportive care has assured enough food).
- Help her to keep drinking water available for herself.

Remove interference
- Help the mother to reduce any milk supplements by 50 ml/day, monitoring weight weekly to reassure her that infant is still gaining 125 g/week.
- Ask her to avoid separation from the baby, scheduled feeding, care of the baby by others, delaying feeds and, as above, giving bottles and pacifiers.
- Help her to prevent a new pregnancy with non-oestrogen family planning methods.

Step 4: Encourage age-appropriate feeding

- Help the mother to establish or re-establish exclusive breastfeeding until the baby is six months old.
- If supplements are needed, teach her to give them by cup, not bottle.
- Show her how to prepare and give adequate complementary foods from six months of age, as well as frequent breastfeeds.

Exercise: Giving relevant information

The mothers imagined below have been in a camp for one week. They are alone with their infants. Their households receive full rations and has adequate fuel, utensils and water. They are not malnourished or ill.

Consider how you might reply to each mother in order to correct her misconception about infant feeding in a friendly, non-critical way.

Mother 1: "My milk is too weak, because I haven't been eating right/enough. I can't breastfeed."

Mother 2: "My milk is going away now. It always goes away when my babies are a few weeks old."

Mother 3: "In this hot place, the baby will be too dry if I don't give her water."

Mother 4: "Babies need to suck a lot. So I use a pacifier between breastfeeds."

Think about your own possible responses, before looking at the ideas/examples of responses below. These show how a health worker has used information to correct the mothers' misconceptions.

Notice that the health worker does not criticise the mothers, or give them instructions.
She also does not lecture them on all the benefits of breastfeeding.
She tries to give them relevant information in an encouraging way.

Possible responses:

1. Health worker: Of course you are worried. (Friendly response, no criticism). But actually, your milk is still exactly right for your baby. The food you are getting here will make good milk.

2. Health worker: Well, milk comes back if you breastfeed more. We can help you increase it, so you make all that your baby needs to grow and be strong. If you do things a little differently this time, you can keep your milk flowing much longer than it did with the other babies.

3. Health worker: You're right to think about giving your baby enough to drink. But all the water she needs is in your breastmilk, and that is cleaner than even boiled water. Whenever your baby is thirsty, put her to your breast and let her drink. It is a good idea for you to drink plenty of water yourself, so that there is plenty for your milk. (Relevant information; notice these are not instructions, just information.)

4. Health worker: Yes, babies really do enjoy sucking. But the safest thing for your baby to suck is your breast. It is cleaner than a pacifier, and the extra sucking for comfort helps your breasts to make lots of milk.

5 More skilled help with breastfeeding

5.1 Further Help for breastfeeding

Basic Aid does not solve all breastfeeding difficulties. Some mothers need a level of care that we call Further Help. This requires more skills, time and attention than Basic Aid. So health and nutrition workers need more training to provide Further Help than they do to provide Basic Aid.

It may be simpler to provide Further Help for breastfeeding than to provide the conditions needed to use breastmilk substitutes safely.

Additional skills required

- Teaching mothers how to express breastmilk by hand. Hand expression is useful in many situations. It is described in Annex 3.
- How to use a breastfeeding supplementer and carry out other supplementation techniques. These are described in Additional Part 6 Relactation, but they are also useful in other situations.
- Help with Kangaroo Care (see below in Part 5.2). This is useful particularly for care of low-birth-weight and sick infants.
- Restorative care for traumatised mothers (see below in Part 5.6).

Temporary supplementary artificial feeds may be needed sometimes. Part 9 Artificial Feeding Options describes methods of preparation and volumes of supplements needed.

Situations for which Further Help is required

- low-birth-weight infants
- babies who are visibly thin, underweight
- babies who refuse the breast
- management of breastfeeding by malnourished mothers
- mothers who are traumatised, in emotional crisis, or rejecting their infants.

Further Help is also needed for:

- relactation (covered separately in Part 6)
- breast conditions (covered separately in Part 7)

5.2 Low-birth-weight infants

In an emergency setting, many babies may be born with low-birth-weights (LBW). A LBW is a birth weight of less than 2500 g.
LBW babies may be preterm or small for gestational age.
Breastmilk, including colostrum, the first milk, is especially important for their survival and health.

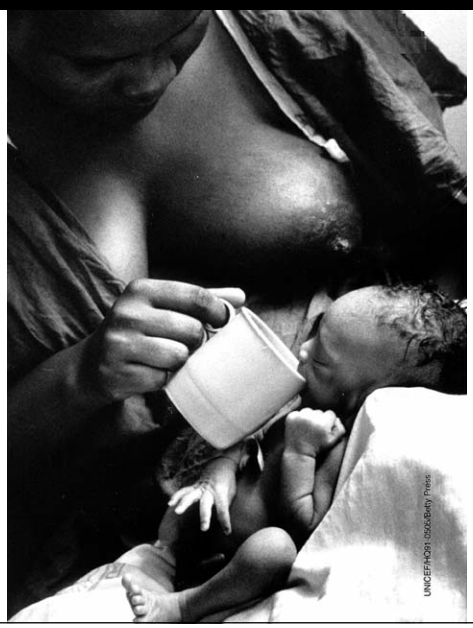
- Help every mother of a LBW newborn to hand express colostrum and milk about eight times every 24 hours, from birth onward (see Annex 3). Starting to express soon after delivery helps to establish lactation. Expressing frequently helps milk production to become established more quickly, even if only a little colostrum is obtained at first.
- If the amount of colostrum expressed is small, use a small sterilised syringe to draw it from the nipple.
- As soon as the infant is ready to take feeds by mouth, give the mother's freshly expressed breastmilk by sterilised tube, syringe, dropper or cup.
- **On the first day,** give 60ml/kg, divided into 12 two-hourly feeds. If insufficient quantities of breastmilk are expressed at first, make up the volume with donated breastmilk which has been heat-treated to prevent the risk of infection. If this is not possible use temporary artificial supplements given by tube, syringe, dropper or cup.
- **Increase the volume** by 20ml/kg per day until the baby is taking a total of 200ml of breastmilk per kg per day, divided into 12 two-hourly or 8 three-hourly feeds.
- When the infant's condition is stable, show the mother how to give Kangaroo Care (see below).
- Whenever the infant shows interest in suckling, encourage the mother to offer her breast. The aim is to discharge the LBW infant on exclusive breastfeeding.

IFE 2/28

Cup feeding a Low-Birth-Weight (LBW) infant **IFE 2/28**

A mother in Kenya feeds her own freshly expressed breastmilk to her low-birth-weight baby. In this maternity facility, mothers help each other to learn the skills of hand expression and cup feeding until the baby is ready to suckle.

LBW infants are discharged exclusively breastfeeding.



Cup feeding a low-birth-weight infant with expressed breastmilk, Kenya.
UNICEF/HO910505/Betty Press

Kangaroo Care

Kangaroo Care means keeping an infant in continuous skin-to-skin contact with the mother or another adult. It is helpful particularly for low-birth-weight babies. The infant is kept near the mother's breast, and is carried and rocked without being urged to breastfeed.
Kangaroo care helps to keep babies warm, and reduces stress. It may also increase the amount of breastmilk produced.
Infants who have never breastfed or who refuse to breastfeed often start breastfeeding spontaneously when cared for in this way.

How to give Kangaroo Care

Kangaroo Care is widely used for preterm infants whose condition has become stable (breathing and pulse especially).

- The mother or other caregiver removes inner clothing.
- The infant wears only a nappy* and head covering if it is very cold.
- The infant is gently held close against the adult's bare chest by any wrapping of cloth that is culturally appropriate.
- The adult wears enough of his or her usual outer clothing to keep warm, and adjusted so that the child's face is exposed to the air and can be seen by the caregiver.

Newborn preterm infants

- The preterm infant is held in an upright position between the woman's bare breasts, or on a man's chest.
- The caregiver can move around and carry out any upright activities, and sleep in a semi-lying down position.
- If a mother or wet nurse are giving Kangaroo Care, the skin-to-skin contact stimulates breastmilk production and increases bonding between the two.

Full term infants and young children

You can use Kangaroo Care:
- for older children, particularly for malnourished children, who are at risk of getting too cold (hypothermia)
- to help with relactation, or to overcome refusal to breastfeed.

Any position can be used that provides plenty of continuous skin-to-skin contact.
Adult and infant can sleep together lying down, covered in the same blanket.

*If the child has diarrhoea, cut a nappy covering from a rectangle of thin plastic sheeting, leaving extra tails at the corners to tie at the sides.

IFE 2/29

Kangaroo Care **IFE 2/29**

To reduce heat loss when very cold cover the infant´s head with a cap or the mother's shawl.

The infant is kept in full skin-to-skin contact with the mother day and night, and breastfeeds as much as his/her condition allows.

Kangaroo Care, pp. 76,79. WHO/IMCI. Management of the child with a serious infection or severe malnutrition WHO/FCH/CAH/00.1

IFE 2/30

Bonding is enhanced by Kangaroo Care IFE 2/30

The infant's hands should be left free so he or she can move them in or out of the warmth.

Kangaroo Care infants may regulate their own temperature in this way.

UNICEF/HQ94-0632/Dora Gutierrez

5.3 Babies who are visibly thin or underweight

An infant who is visibly thin (or, if weighing and measuring is possible, underweight) may be:

- *mildly malnourished* (-2 Standard Deviations to –1 Standard Deviation of weight-for-length, or 80-89% of the median)
  or
- *moderately malnourished* (-3 SD to –2 SD of weight-for-length, or 70-79% of the median)[1].

To help a thin or underweight infant:

- Evaluate the infant's health to rule out underlying illness, and treat infection if present.
- Carry out Full Assessment Steps 1 and 2 (see Part 3).

If the infant is still breastfeeding at all:

- Give Basic Aid for breastfeeding, to establish or re-establish age-appropriate feeding, and to increase breastmilk volume.
- If the infant is under six months and breastmilk production is low, the mother may need to give temporary artificial supplements until she can exclusively breastfeed. Teach her to give the supplements by cup, after breastfeeds, and to decrease the amount by 50 ml each day.
- If the infant is over six months, help the mother increase breastfeeding and give nutrient-rich complementary foods.

If the infant is not breastfed:

- Carry out Full Assessment Steps 2 and 3 (See Part 9.10 for FA Step 3).
- Consider relactation, and discuss it with the mother or caregiver if it is likely to be possible.
- If relactation is not possible, discuss artificial feeding options (see Part 9) with the mother or caregiver.

For all infants:

- Give mothers extra and frequent reassurance, praise and help, to build their confidence.
- Show the mother how to give extra warmth, stimulation and play, to make her infant more alert.
- Follow up and weigh each infant weekly until weight gain is established (at least 125g/week, 500 g/month) and appetite improves.
- Repeat Full Assessment Steps 1, 2 and 3 after treatment, as appropriate, to ensure that previous feeding difficulties have been overcome.

[1] Severely malnourished infants (under –3 SD W/L or under 70% of the median) and any with pitting oedema (bilateral swelling that pits on pressure) should be referred to a Therapeutic Feeding Centre or hospital with their caregivers (see Part 8).

5.4 Babies who refuse the breast

A healthy baby who has been breastfeeding may refuse the breast due to bottle feeding or some upsetting change in care.

A health or nutrition worker can help re-establish/restart breastfeeding:

- Advise the family that only the mother should care for the infant.
  Keep mother and baby in close skin-to-skin contact day and night, using Kangaroo Care if appropriate.
  Encourage the mother to stroke and talk to the infant to comfort him or her.
- Help the mother to **hand express** as much milk as she can,
  eight times or more per day, to build up milk production.
- Feed the infant with the expressed breastmilk by cup, using no bottles or pacifier.
- If breastmilk production is low, give temporary supplements until milk production increases. Give supplements by cup, after all available breastmilk has been given.
- Offer the breast whenever baby is sleepy or relaxed, or after a small cup feed.
- Help the mother to relax; assure her that breastfeeding can be restored.
- Try different positions if baby is uncomfortable. Ensure good attachment if the baby breastfeeds in a new position.

5.5 Management of breastfeeding by a malnourished mother

If a mother is malnourished, she needs care and feeding for herself, before she can adequately care for her child.

Caring for the mother

- Feed a malnourished mother according to established principles .
- When her appetite recovers, give her a mixed, nutrient- and energy-rich diet, encouraging her to eat as much as she can.
- Provide her with unlimited access to drinking water and other fluids.
- Listen to her throughout this process. Learn her difficulties, and help her to talk about them, including any that might affect her ability to breastfeed and care for her child.

Caring for her child

- Keep mother and child together. If there are more children, keep them with the mother too if possible. Unnecessary separations may put at risk the breastfeeding of an infant and the feeding and care of other children.
- As soon as the mother's condition permits, encourage her to let her child suckle as often as s/he is willing.
- Build her confidence by explaining that her milk is still nourishing, and the best food for her baby even when she feels weak. Reassure her that, if her infant suckles often, she will soon have plenty of milk again.
- If her breastmilk supply has decreased, give artificial supplements by cup or breastfeeding supplementer. Encourage the infant to suckle as often as s/he is willing, until breastmilk production has increased (see Part 6, Relactation).

> *Mothers' and health workers' confidence in breastfeeding is often shaken when they see a malnourished infant attached to the breast. If there is a rush to rehabilitate the infant, forgetting about the mother, then there is a risk of discharging a healthy infant with no secure supply of food.*
>
> Mary Corbett in Field Exchange 9, March 2000

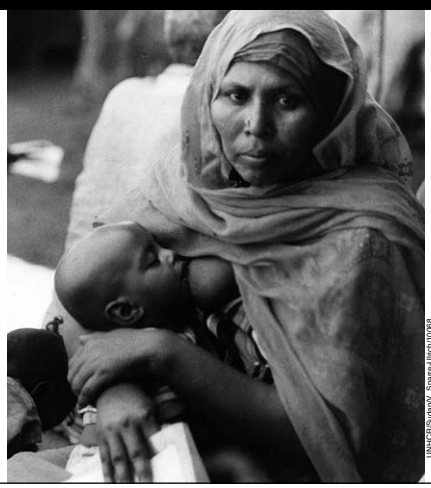
5.6 Mother traumatised, in emotional crisis, or rejecting infant

Stress does not prevent mothers producing breastmilk. However, traumatised and depressed women may have difficulty responding to their infants, letting their milk flow, and feeling any confidence.

IFE 2/31

The need for restorative care IFE 2/31

Stress, trauma, grief, or sexual violence do not spoil a mother's breastmilk, but she needs care that helps to restore her emotional balance.



The need for restorative care. UNHCR/Sudan/V.Sparre-Ulrich/10068

A woman may believe that stressful events in her life have caused a decrease in milk production. She may give her baby artificial supplements so the baby suckles less at the breast and breastmilk production really decreases. Often a health or nutrition worker does not see a mother like this until she has already stopped breastfeeding.

Bereavement, anxiety over missing family members, and the effect of torture or horror can exhaust a woman's emotional resources even more. She may believe that persistent grief spoils breastmilk or makes her unable breastfeed.

A woman may have experienced sexual violence and feel that she and her breastmilk is contaminated. A woman may reject her infant for different reasons. For example, if she suffered severe psychological trauma if her pregnancy was caused by rape, if there is severe conflict with the family, if the child is abnormal, or if she believes the child is dying. The rejection may be temporary or long term.

A woman who is unable to respond to her infant may breastfeed less, and her breastmilk production is likely to decrease as a result. Her baby may not respond to her, and may not demand to be fed. If a woman does not receive emotional care, the result may be that the infant fails to feed, fails to grow and fails to develop psychologically.

Stress, trauma, grief, and sexual violence do not spoil a mother's breastmilk, but she needs restorative care.

Restorative care

Care that restores a woman's emotional balance may help. Care for violated women should include measures to support them, as far as possible within their religious and cultural traditions, and to help them want to breastfeed again.

- Sit with the mother and family and listen and talk in a friendly manner.
- Seek people close to the mother to give her companionship and the kind of touch she may find comforting.
- If the woman has come to believe that she cannot be a good mother, try to give her back her feeling of self-respect.
- Keep the baby in skin-to-skin contact with the mother, and find reassuring companions, perhaps older women, to help her accept the child.
- If necessary, feed the baby temporary artificial supplements by cup, and give Basic Aid until breastfeeding starts again.
- Use culturally appropriate means of "cleansing" the mother and her breasts to help her be willing to breastfeed again.
- In severe cases, consider temporary use of appropriate psychiatric drugs (i.e. that may be used safely by breastfeeding women (see Annex 1). Encourage her to continue breastfeeding and monitor the baby for drowsiness and adequate weight gain.

Self-massage for traumatised women

A massage therapist working with survivors of torture and sexual abuse suggests a role for self-massage, adapted to a woman's culture.

"Often trauma means that a person is caught in constant thought and separated from their emotions and the feelings of their body. One could teach mothers a simple breast massage to do on themselves. It could be something easy and slow to help women regain contact with themselves and feel emotions again.

During this brief massage of about five minutes, they could think about giving themselves messages that encourage breastfeeding. For example:

"I have given birth to this beautiful baby and now I am going to give life-giving milk.
With this massage, I rest my body and prepare my breast to give life to my child.
I will give food to my child and make him/her strong."

adapted from John Calvi, 2001

Case study: A depressed mother

A mother came to the health service asking for infant formula for her one-month-old infant who weighed 4.4 kg. She was referred to the Breastfeeding Counselling Unit. The breastfeeding counsellor learned that the mother was emotionally depressed and under stress because of her situation at home. The infant's father was mentally ill and sometimes beat the mother and her children.

Due to this situation, relatives and neighbours had told the mother that her breastmilk was not good and would make the baby ill. So she felt that she could not breastfeed.

The counsellor talked with the mother, reassuring her of her ability to breastfeed and trying to build her self confidence. She reminded the mother of the Prophet's words about breastfeeding from the Quran.

The counsellor asked the mother to breastfeed in front of her to show her how she breastfed. She helped the mother by rubbing and touching her shoulders. She asked the mother to look at her baby's eyes and touch her cheeks, thinking only of her baby until the milk flow started.

The counsellor started to teach the mother how to decrease the number of artificial feeds gradually and increase the number of breastfeeds. The mother first decreased daytime formula feeds from five to three. Then she gave breastfeeds only during the night, for three days. Over the next three days, the mother gave only one formula feed per day, and after that she breastfed exclusively day and night.

The counsellor visited the family at home and talked to the mother-in-law, asking her to help the infant's mother with breastfeeding and to support her through her problems. By the time the infant was four months old, she was exclusively breastfed and weighed 6.9 kg.

From nutritionist Amani Jouda, of Ard El Insan, Gaza, 2001

Case study: A mother afraid to continue breastfeeding

Mother: "I am crying all the time, and my aunt tells me that spoils my milk. That and...well.... something terrible that happened to me on the road. There were some soldiers….I could not get away. I am so ashamed, and now my milk is spoiled."

How can the health or nutrition worker help this mother and her baby?

Consider what would be appropriate in the culture where you are working. The responses below are not the only possibilities.

Possible responses:

Make sure the baby is given appropriate feeding by cup, and help the mother to hold and cuddle the baby. Listen and learn – let the mother talk and cry, and touch her to comfort her. Gradually introduce the idea that she might be able to get cleansed and breastfeed again in the future – perhaps expressing her milk could help.
Find someone from her social group who can be with her and talk to her and help her with the baby. Ask if they know how to cleanse a woman who has had this experience.
Invite her to join a group of women with babies, to be with them and perhaps in time to talk with them.

> *If breastfeeding by the natural mother is impossible, make appropriate choices among alternatives (wet-nursing, breastmilk from milk bank, locally purchased infant formula, home-made infant formula).*
>
> 5.2.1. Operational Guidance, v2.1, February 2007

5.7 Other breastmilk options

Wet nursing

Wet nursing means breastfeeding a baby to whom one did not give birth. Wet nursing may be the best way to feed unaccompanied or orphaned infants. Possible wet nurses include:

- A grandmother or other female relative of a motherless child. Relactation is possible even years after the relative breastfed her own children, and even after the menopause.
- A woman who has recently lost her own infant.
- A woman who is breastfeeding her own infant, also breastfeeding a motherless infant. Supportive care and Basic Aid can help her milk production to increase to meet the needs of both babies.

Health and nutrition workers can tactfully correct any misconceptions about wet nursing as they discuss these possibilities with an infant's surviving family members.

Always offer a potential wet nurse **voluntary and confidential counselling and testing for HIV,** and check she is HIV-negative. Advise her that she must remain uninfected while feeding the infant, and help her to protect herself from any exposure.

Make sure that the wet nurse receives the **additional food and other resources** that all breastfeeding women get. Give the baby temporary cup-fed milk supplements until the wet nurse has plenty of breastmilk. **Follow-up the baby closely** to make sure weight gain is adequate.

Use of donated breastmilk

Infants in hospital can be given heat-treated expressed breastmilk donated by other mothers. If available, this may be particularly useful for severely malnourished infants under six months old, in the initial feeding phase (see Part 8).
The milk should be hand expressed and then:

- boiled, or
- held at 65 degrees Celsius for 30 minutes.

This treatment kills bacteria and viruses, including HIV. After heat treatment, the milk should be refrigerated if it will not be quickly used.

Formal breastmilk banking requires staff experienced in milk banking with standard milk banking procedures and safety precautions. These are difficult to achieve under emergency conditions. Even in stable conditions, banked breastmilk is usually not a realistic way for long term infant feeding.

Left to right: UNICEF, Somalia; Guatemala/LINKAGES, Maryanne Stone-Jimenez; M.Jakobsen, Guinea Bissau, 1987; Mae La camp, Thailand, O.Banjong, 2001; Breastfeeding supplementer, Mike Golden; Peru, WHO/PAHO; Domasi Rural Health Clinic, Malawi, St Louis Nutrition Project, Heidi Sandige, 2003; Mother and child, Valid International.